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The Newsweekly for Pharmacy

C&D

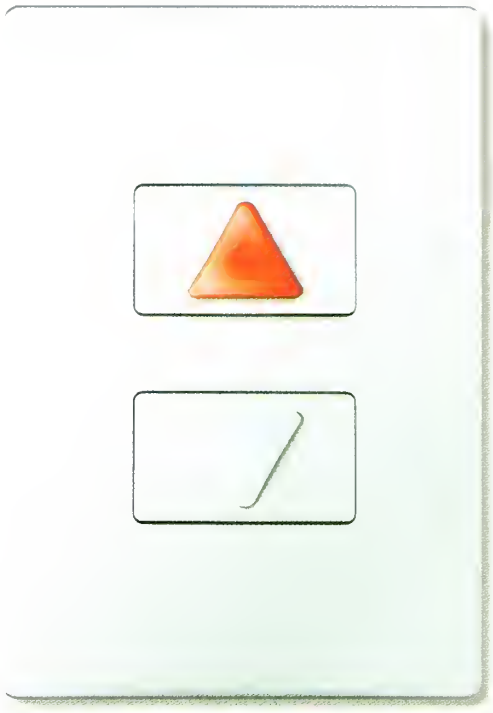
20 November 2004

Public health Paper upbeat for pharmacy

Counterfeiters to hit UK, says think-tank

NHS files £94m claim in generics case

RPSGB spells out impact of Shipman report



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Plans for pharmacy on public health agenda

by Adrienne de Mont
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The Government will put in place measures to make the most of pharmacists' contribution to public health, its White Paper for England pledged this week.

"Working at the heart of the communities they serve, [pharmacists] have real opportunities to offer health messages and advice on issues such as diet, physical activity, alcohol, stopping smoking and looking after our own ailments ourselves," says the *Choosing Health* document.

Further, the strategy for pharmaceutical public health, to be published next year, will show how pharmacy can contribute and will propose new services (*see also p12*).

A whole chapter of the 200-page White Paper is devoted to the introduction of NHS-accredited health trainers, who will support anyone who needs help in making healthier choices, and personal health kits to help people identify their health priorities. Although pharmacists are not specifically mentioned, the section is illustrated by a picture of two young men standing at a pharmacy counter.

The "friendly, approachable and understanding" personal health trainers will give practical advice on stopping smoking, healthy eating, safe sex, doing more exercise, and dealing with stress or social isolation.

"While there will be a core set of skills that every health trainer will need to receive accreditation, local models will need to build on the skills and strengths of the people who are already working in these kinds of role."

In areas of marked health inequalities, new staff may be recruited and trained in this work.

Other plans that could impact on pharmacy include:

- Accelerated implementation of a national screening programme for chlamydia, to cover the whole of England by March 2007. Steps to introduce and evaluate chlamydia screening in pharmacies will start in London.
- Action to restrict further the advertising of infant formulas.
- Training to ensure that all health professionals are able to identify early alcohol problems.

There will also be early focus on:

- Sexual health – a new national campaign targeted at younger men and women to persuade them of the benefits of using condoms.
- Obesity – a new campaign to raise awareness of the health risks and the steps people can take to prevent it.
- Smoking – a boosted campaign to reduce smoking rates and motivate smokers to quit, including access to NHS support such as NRT.

In his introduction, health secretary John Reid, said: "Health improvement depends upon people's motivation and their willingness to act on it." The Government will provide practical support and improve access to services so healthy choices are easier to make.

The Royal Pharmaceutical Society welcomed the White Paper, saying: "Public health needs pharmacy if it is to meet the enormous challenges that the NHS is facing."

Pharmacists are already developing innovative ways of improving people's health, the Society says. "We must continue to utilise this expertise and support the NHS at a local and national level."

National Pharmaceutical Association chairman Ash Soni said many of the White Paper's aims integrate with the strong emphasis on health promotion in the essential services level of the proposed new pharmacy contrac

"This will allow local pharmacists to further improve t health of the nation and reduce health inequalities... the initiative in the White Paper have the potential to play a hugely importa part in turning healthcare in England from a sickness service t a health service," he said.

Drug reps likely to target pharmacists who prescribe in the future

Pharmacists and their staff are likely to be increasingly targeted by the pharmaceutical industry as more achieve independent prescribing status, MPs heard last week.

As more pharmacists become involved in prescribing, drug representatives might approach them, Rob Darracott, RPSGB corporate and strategic development director told a Commons' health select committee last week. NPA chief executive John D'Arcy agreed nd added that it was early days pharmacist prescribing and doubt [drugs representatives] will have some influence".

Mr Darracott said the RPSGB had no record of a pharmacist being struck off its Register for inappropriately supplying quantities of OTC medicines because of the influence of the pharmaceutical industry. But committee member Jon Owen Jones MP argued that this could mean the regulatory system was inadequate rather than perfect.

Community pharmacists would use the Yellow Card Scheme more for reporting adverse events if they had access to patient medication records and could complete a full report, said Mr Darracott. The NPA had no problems with the scheme remaining voluntary, said Mr D'Arcy.

Although pharmacists' involvement was in its early days, he recommended that the committee wait and "see how the voluntary scheme works" before making it mandatory.

The latest session of the committee's inquiry into the influence of the pharmaceutical industry also heard evidence from the Royal College of Psychiatrists, the Royal College of General Practitioners and the Royal College of Nursing.

Fee levels are agreed

PSNC has agreed to an offer fro the DoH that will keep fees and allowances at existing levels for this year.

This will be subject to contractors accepting the new contract proposals, a decision th will be announced at the end of this month

PSNC will issue guidance for LPCs on implementing the new contract. There will also be even for LPCs, PCT and PEC pharmacists in the New Year to support contract implementatio

- PSNC's community pharma conference returns to Manchest on October 12, 2005.

UK is target for counterfeit drugs, says think-tank

The UK could become a big new market for counterfeit drugs, a European think-tank has warned.

The free movement of pharmaceuticals through Europe and the current need for repackaging (in the appropriate language) makes it easier for counterfeit pharmaceuticals to be sold through the legitimate distribution chain, Graham Satchwell, a former police officer, says in a report for the Stockholm Network.

Mr Satchwell called for greater awareness, a co-ordinated effort to combat counterfeiting, an urgent review of the methods by which products are repackaged for sale in the UK, and to uniquely identify each medicine pack using RFID tagging, in his report *A Sick Business – counterfeit medicines and organised crime*. "It is true that plenty of controls are in place, but I'm not sure that they're adequately policed," he said. "No one knows the scale of the problem but it is growing, year-on-year."

The MHRA, however, said it did not endorse the publication and added that cases involving counterfeit products were relatively rare in the UK.

Commenting on the report, BAPW chairman Steve Dunn said wholesalers had reasonably robust policies in place to combat counterfeiting.

Following the Cialis and Reductil incidences, Mr Dunn said members had updated processes, checking goods as they came into their warehouses and verifying sources. "It is certainly true that counterfeit drugs are a big market in the US," added Mr Dunn, "but some of the report's claims are a bit scare mongering."

The report said Europe and North America provided the best return on investment for those involved in the supply of counterfeit products.

It claimed there was no effective method within the UK of identifying counterfeit pharmaceuticals before they were dispensed.

Mr Satchwell was critical of parallel traders and said they provided an easy route of entry for counterfeit drugs, an argument refuted by Mr Dunn, who said: "I don't think associating parallel importers with counterfeit drugs is a legitimate argument. I don't think it's true."

ABC Pharmacies – clarification

In a Statutory Committee report published in *C&D November 13 p24*, concerning the dispensing of prescriptions supplied by an internet business at a branch of ABC Drugstores Ltd at Portobello Road, Notting Hill, it was implied that should the allegations be proven it could put ABC Drugstores out of business. We would like to make clear that this is not the case. ABC Drugstores operates 24 other pharmacies in the London area and the future of those pharmacies will be unaffected by the Statutory Committee proceedings.

Patient CPD suggested

Patients with chronic conditions like diabetes could benefit from training in their treatment, just like the CPD required by health professionals, Professor Robert Anderson of Michigan University has said.

Most health systems were designed for the treatment of acute diseases and a new approach is needed in cases where the patient carried out the day-to-day management of disease, Professor Anderson explained at last Friday's Diabetes Scotland Conference in Glasgow.

"Once a diabetic patient leaves the consulting environment the management of the disease is subject to his or her behaviour – the health professional effectively loses control," he said.

Chronic treatment was most effective when practised within the context of a partnership between patients, their families and the health professions, he told the audience of health professionals, patients and social services staff. Patients should be empowered by having access to appropriate information followed by guidance on how to reflect and set goals.

This would allow clinical management plans to be tailored to patients' personal aspirations and circumstances, and enhance their motivation to concord with advice given by health professionals. Crucial to the process was a self-evaluation plan to see if the goals were being

Isle of Man unveils own strategy

Isle of Man pharmacy contractors and their governing health body, the Department of Health and Social Security, have published their strategy for pharmacy.

It will inform local politicians and key opinion formers how England's new pharmacy contract, which Isle of Man contractors are also tied into, will be taken forward, Peter Curphey, chairman of the Isle's Pharmacy Contractors' Association (PCA) said.

This will include, for example, how the autonomous Isle of Man government will take forward the enhanced service tier of the new contract, as well as those elements of the new contract that are embedded in English legislation, for example those relating to waste management or disability discrimination.

"The aim," says Mr Curphey, "is to take the pharmacy contract and 'Manxify' it. However, while we appreciate that the new contract needs to be recognisable here, we do accept that there is no point in being different just for the sake of being different."

The 24-page strategy comprises 20 action points in four key areas: improving the use of medicines, quality and safety, access and redesigning of services around patient needs, and barriers and drivers.

Key areas for action include:

- That a scheme should be established, allowing patients at greatest risk of incorrectly using their medicines, to have their medication reviewed by a pharmacist at least once a year.
- That the DHSS should establish a scheme to formally link community pharmacists with GPs and other prescribers to provide prescribing advice.
- That pharmacists should identify the most suitable minor ailment schemes for the Isle of Man.
- That the DHSS, in conjunction with the PCA, should investigate the resources required for consultation rooms.
- That the DHSS and the PCA should discuss the appropriate level of support to help community pharmacists take part in clinical governance.
- That systems need to be developed to identify poorly-performing pharmacists and define protocols for remedial action.
- That the DHSS should centrally fund continuing professional development and fund and encourage formal training for pharmacy support staff to a nationally recognised level.
- That a properly funded on-cal service be established.
- That there is a need to develop systems for repeat dispensing.
- That the use of electronic prescribing and the linking of prescribing and dispensing systems in primary and secondar care and the electronic patient record should be investigated.

The Isle of Man currently has 24 pharmacies, providing service to a population of around 75,000

NHS fraud busters seek compensation

The five pharmaceutical companies suspected of price-fixing in relation to ranitidine are facing damages of £94 million, the NHS Counter Fraud and Security Management Service has announced.

This comprises a claimed loss of £69,252,415 and interest of £25,201,902.

The secretary of state for health, the Prescription Pricing Authority and the 28 English strategic health authorities filed the formal assessment of damages relating to the sale and supply of ranitidine in the High Court on October 28. The companies facing the action are Generics UK Ltd, Ranbaxy UK Ltd, Norton Healthcare Ltd, Norton Pharmaceuticals Ltd and Kent Pharmaceuticals Ltd.

The CFSMS is currently conducting investigations into suspected fraud relating to the sale and supply of three drugs, ranitidine, warfarin and penicillin.

Although the first started two years ago, there is still little progress to report. There have been no out of court settlements and no money has been recovered.

Commenting, CFSMS chief executive Jim Gee said: "The NHS continues to pursue vigorously each of the civil claims we have initiated. We are absolutely determined to protect the NHS from unlawful behaviour and to ensure that its resources are properly applied to patient care."

Shake-up planned for MHRA

Health minister Lord Warner has announced radical changes to the UK medicines regulatory body to make it more open and transparen

Members of the MHRA's committees will be subject to stricter controls over possible conflicts of interest under the proposed new legislation (*C&D, November 20, p6*).

Chairmen and members of the new commission – a merger between the Committee on Safety of Medicines and the Medicines Commission – will not be allowed to hold interests in the pharmaceutical industry. They will be held accountable to a revised code of practice, on which the MHRA has opened a consultation. This move is "to ensure impartial advice is given o regulation of medicines".

The new commission, provisionally called the Committe for Safety and Efficacy of Medicines, will advise ministers o regulatory matters for human medicines. Its remit will be to exercise judgement based on medical and scientific evidence, but representing a "wider risk-benefit judgement".

The proposed amendments require legislative change and are likely to be put before Parliament by the end of March 2005.

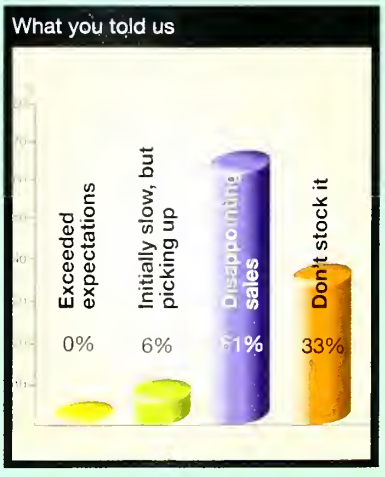
Questiontime

Last week we asked: In light of the adverse media coverage for OTC simvastatin, how well has it been selling in your pharmacy? You replied (see right):

This week's question: Given the choice, which public health issue would you most like to tackle?

- Smoking
- Obesity and exercise
- Sexual health
- Other

You can record your vote on our website: *www.dotpharmacy.com* You have until noon on November 23 to cast your vote. We will publish the results in *C&D*, November 27.



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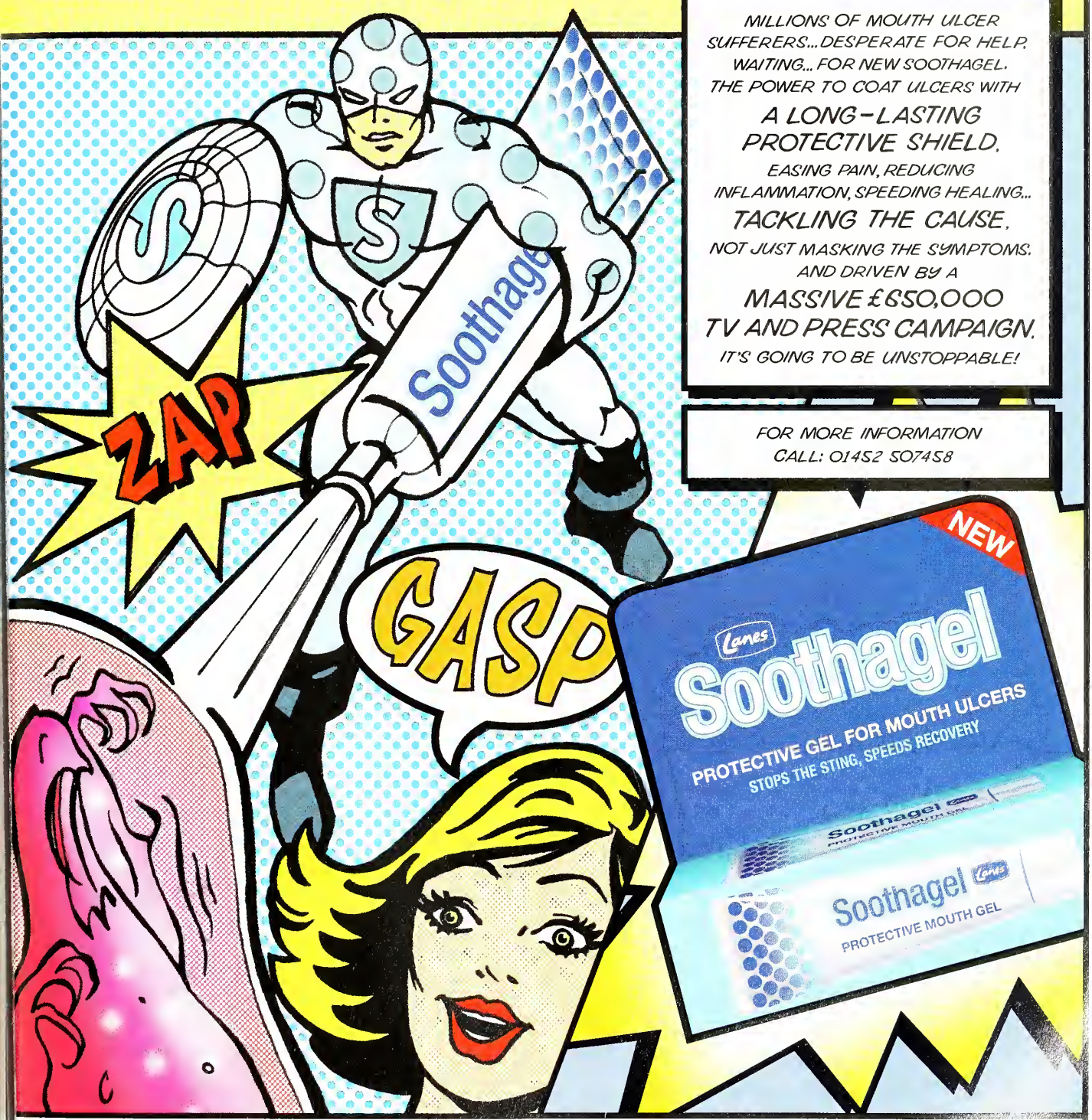

SEALS OUT PAIN - SEALS IN HEALING

PPRS cuts will cost contractors thousands

Community pharmacists will lose thousands of pounds following the recent 7 per cent price drop on branded pharmaceuticals, wholesalers' representatives have warned.

Calling the recent Prescription Price Regulation Scheme renegotiation a "double whammy" when linked with the £200 million drop in generics payments, Steve Dunn, chairman of the British Association of Pharmaceutical Wholesalers, estimated that the collective effect of the PPRS and the generics pricing changes could take £4,000 out of the average pharmacy.

"On top of the radical revision of generic drug remuneration this is just another way of stripping cash out of pharmacy and pharmaceutical wholesaling."

The Association of the British Pharmaceutical Industry has also slammed the recent PPRS price cuts as unnecessary, against the backdrop of a fall in medicines prices in real terms of some 15 per cent over the past 10 years.

But it has recommended the terms of the scheme to members on the basis that it secures the provision of safe and effective medicines for the NHS at reasonable prices; promotes a strong and profitable pharmaceutical industry capable of sustained research and development expenditure; and encourages efficient and competitive development and supply of medicines.

The ABPI said the PPRS agreement contained new measures specifically designed to help its smaller members. This included increasing the turnover level at which companies routinely have to report financial data from £1m to £5m, thus eliminating some smaller companies from the whole process.

Business rate relief is there, but is not automatic

Relief may be available for small firms facing increases in their business rates – but only if you actively look for it, the Federation of Small Businesses is advising.

Following the publication by the Government last month of new summary valuations of commercial property, the FSB believes that up to 40 per cent of firms across England and Wales will face substantial rises once the new rates come into effect from April 2005.

Pubs, restaurants and shops are likely to be among the hardest hit, the FSB says.

But under proposals to be confirmed in January 2005, firms with a rateable value of between £5,000 and £10,000 will be entitled to special rate relief of up to 50 per cent. There will also be a buffer zone for business properties with a rateable value of between £10,000 and £15,000 who will not have to pay more.

Commenting, FSB business rates spokesman Roger Culcheth said: "The Government is financing the relief rates scheme by applying a surcharge on more expensive properties.

"There is help out there for small businesses but they must be ready to go out and get it. The relief is not automatic."

For more information:

www.voa.gov.uk

Pre-reg insurance

The Pharmacists Professional Indemnity Ltd has launched an insurance policy for pharmacy students and pre-registration trainees.

The policy is underwritten by the Chemists' Defence Association, an NPA subsidiary company, and costs £15 per year. It provides £250,000 of legal defence cover and £50,000 of professional indemnity cover.

Mark Koziol, director of the Pharmacists' Defence Association, which also provides indemnity protection, highlighted the importance of individual practitioners having their own insurance.

Contract optimism from Numark

Numark pharmacists were cautiously optimistic in advance o the new pharmacy contract, a survey by the virtual chain has shown.

Almost half of the respondents said they were looking forward to the contract, and 45 per cent thought it was a positive change. The majority (80 per cent) said it would shake up their current way of working and change the focus to extended services and away from dispensing.

Other key findings of the surv include: 64 per cent have installe consultation areas/rooms; 25 pe cent employ a second pharmacis and 80 per cent had spoken to their PCT community pharmacy facilitator.

Numark members who complete the questionnaire will receive a personalised report, benchmarking their business an questionnaire response against similar pharmacies nationally an locally. It will include a suggeste development plan with timescal and information on resources available to implement it.

The initiative – known as Extend – is a three-phase programme launched in August and the survey was the first pha In the second phase, Numark members will feed back on how they match up to their PCO's expectations.

The third phase will include specific initiatives in areas including osteoporosis, weight management and cardiovascula

For more information:

www.numarkpharmacists.com

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NPA VIEW

Cracking the contract

John D'Arcy, NPA chief executive, says it's time to embrace the opportunity for change which the new contract offers

The new pharmacy contract has arrived – assuming that there is a positive vote in the forthcoming ballot. And already it's attracting mixed views: some suggest it doesn't go far enough; others express concern about the difficulties associated with fitting new roles on top of what is, by any standards, a full time job.

Whatever your view, it is abundantly clear that the new contract represents a significant milestone in community pharmacy's development and is an opportunity that must be seized.

A core objective of the contract is to harness the skills of pharmacists and their staff. This is something we all welcome. If community pharmacy is to make a success of the new contract – and to enjoy the rewards associated with it – we must ensure that as pharmacists we are up to the job and possess the skills and competencies required to practice in a modern environment. But it is not just pharmacists who need to have the necessary skills. The same is true of all pharmacy staff.

The new contract will result in pharmacists engaging in more 'hands on' patient care. Overall responsibility for patient care will continue to rest with the GP – so a strong professional relationship between pharmacists and GPs is essential, particularly in respect of the advanced services.

Relationships with primary care organisations are also critically important. The contract provides the opportunity for pharmacy to engage PCOs in strategic discussions around how it can help PCOs deliver health targets and outcomes. A pharmacist on the management committee of the PCO is an absolute must.

And we must not forget the most important person of all: the patient. The NPA's Ask Your Pharmacist campaign has done a great job in promoting pharmacists as qualified health professionals to patients. But the new enhanced roles will need to be sold to patients – and this presents an opportunity for a review of our campaign messages.

While the concept of a new contract and an increased emphasis on a clinical role may at first sight appear daunting, it should be regarded as a framework for delivering roles which, with one or two exceptions, are already being delivered by many pharmacies. Accordingly, a large number of the resources that are needed to deliver the new contract are already out there.

The job now for the NPA is to re-examine these resources in the light of the new contract to ensure their relevance and to fill any gaps through the development of new materials. The NPA is actively working on our new contract 'survival kit' to provide members with the information necessary to understand the structure and requirements of the new contract and, where necessary, with model standard operating procedures to support each of the new roles.

No contract can ever be perfect, particularly as we are trying to satisfy a variety of aspirations both within and outside the profession. But we believe that the new contract provides a structure and funding that will allow the profession to evolve. Yes, it will result in enormous change – and members will undoubtedly need substantial support through this.

But the ultimate prize of a more rewarding future, along with greater recognition for an enhanced clinical contribution, has to be worth the effort.

A key strand of the NPA's work programme over the coming months will be to provide a robust support package to help members 'crack the contract'!

Contract roadshows focus on PPRS

PSNC used last weekend's contract roadshow in Bristol to reassure contractors that purchase profit on branded pharmaceuticals was secure in the new global sum despite the recent 7 per cent price cut announced in the new Pharmaceutical Price Regulation Scheme (*C&D, November 6, p10*).

Bristol contractors also used their roadshow to raise concerns about the new contract's failure to account for varying pharmacy business rents and the lack of obvious funding for care home servicing.

Contractors voiced concern about the possibility of future Government clawbacks, points that PSNC chief executive Sue Sharpe recognised.

However, she reassured contractors that PCTs would have to rise to the challenge of their new supporting role for the new pharmacy contract, but reminded LPCs that it is up to them to negotiate and come up with the best possible solution.

In response to contractors' concerns about repeat dispensing, she highlighted how contractors should work towards the ideal of 28-day prescriptions.

On the whole, Bristol contractors, as well as those attending the parallel Nottingham roadshow, left the meetings in a positive mood.

Said Avon's Mr Moul: "I don't know of anyone who is planning to vote no.

"We recognise that the new contract is the only option; the alternative is to continue the way we are doing and be squeezed and squeezed by the Government.

"We believe that PSNC has come up with a cracker of a deal."

Particularly welcome, he said, were PSNC's reassurances that the onus would be on PCTs to disprove, rather than contractors to prove the suitability of their consultation room when claiming funding.

Contractors also welcomed the opportunity to go through specific financial details. The pricing benchmarks for medicine use review (£23 for a 20-minute review) will be "a useful grounding on which to base further negotiations with PCTs", said Mr Moul.

He also reported that there was relief among contractors to learn that one full time equivalent in staffing terms equates to 37.5 hours. This means a pharmacy open for 45 hours a week is already supplying approximately 1.20 FTE equivalents.

Nottinghamshire LPC secretary Barry Besbrode reported that contractors in his area generally come away from the meeting in Nottingham satisfied with the answers they received.

"The majority of contractors feel that the way forward may not be smooth but it is important that we do move forward.

The Government clearly expects all its healthcare professions to have a new contract and we all know that imposition remains an option.

"The contract offers us the chance to develop professionally. I hope contractors will embrace it."

Avicenna calls for contract funding details

Independent contractors are having to vote on the new contract without knowing how the funding proposals were developed, Salim Jetha, chairman of the buying group Avicenna has said.

Salim Jetha: our members have a difficult choice

The funding is based on a fair return on investment, but this information has not been made available to independents, even though the multiples had access to it via their representation on PSNC, Mr Jetha claimed.

"If the information is classified, then a meeting of representatives from all the independent groups such as ours – which account for well over half the independent sector – could help diffuse the confusion," he added. "Our members are experiencing a difficult choice – making a decision in a limited time frame and based on a lack of total transparency," he said.

Wales aims for April start for contract

Welsh pharmacists should also have their new contract in place from April, health minister Jane Hutt revealed at Community Pharmacy Wales's inaugural annual dinner last week.

However, Wales's contract could place greater emphasis on health promotion and preventative measures than its English counterpart does, with pharmacists being more actively involved in day to day patient care.

This involvement could take the form of 'directed' enhanced services such as smoking cessation, Peter Haydn Jones, chief executive, Community Pharmacy Wales said.

Surrey pharmacists paid for script intervention

Pharmacies in East Elmbridge & Mid Surrey PCT are being paid £5 for prescription intervention in a pilot running until March 31.

The aim of the EEMS PCT community pharmacy intervention scheme is to support the PCT's prescribing financial recovery through savings on expensive or over-prescribed drugs. Community pharmacists in the area are being paid to identify those interventions, which support the pilot's aim, up to a maximum of 40.

Pharmacists will also be paid the intervention fee if they make other interventions that save the PCT in excess of £20 per annum.

Under the scheme, pharmacists should:

- Discuss the proposed intervention with the patient.
- Forward the prescription to the practice on a special PCT community pharmacy referral form, and
- Record details of the intervention on the EEMS PCT intervention claim form.

The PCT plans to pay when a block of 10 accepted interventions has been completed.

PCT chief pharmacist Vanessa Lane said that if the pilot was successful, the PCT would consider more quality and therapeutic prescribing interventions and roll out the scheme on a long-term basis.

The scheme has the support of the local LPC and the Medicines Management Committee. Commenting, Alan Rogers, vice-chairman of Eastern Surrey LPC, said: "Two days into the scheme and I have already saved the PCT several hundreds of pounds."

MULTIPLES

Boots offers points on scripts

Boots The Chemists claims it is not acting unprofessionally in offering Advantage Card points to patients signing up for its prescription collection service.

The company is targeting a "limited number" of customers aged over 60 with a voucher offering 250 points (equivalent to about £2.50) to join the service.

A Boots spokeswoman said: "Patients retain absolute freedom to use the pharmacy of their choice for their prescriptions." No prescription is needed to register.

Lynsey Balmer, the Royal Pharmaceutical Society's head of professional ethics, said the *Code of Ethics* does not specifically prohibit the offer of a gift or reward to patients who elect to use a particular service.

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For fast and effective fever relief.

Pharmaceutical Public Health Conference

Turning points in public health

On the eve of the Government's Public Health White Paper, **Adrienne de Mont** reports from a conference which discussed a public health strategy for pharmacy

The idea of building public health into the new pharmacy contract is a "very important step forward", believes the Department of Health's chief pharmacist.

For the first time, pharmacists will be paid to carry out substantial public health roles as part of their core services – a move Dr Jim Smith thought was "quite a radical departure".

Pharmacists would be obliged to support local public health campaigns, carry out brief interventions on prescription-linked problems such as weight reduction and smoking cessation, and signpost patients to other health professionals when necessary.

Dr Smith was speaking at a conference on the progress of the Department's pharmaceutical public health strategy, which is being developed in collaboration with pharmacy and public health bodies. When a satisfactory draft is agreed, it will be put to ministers with the aim of launching a document in the first half of next year. Dr Smith said it would be a huge opportunity for pharmacists to play a central role in public health and would enable the Government to make the best use of their skills.

'Sex-up' public health

Royal Pharmaceutical Society president Nick Wood warned that there was a danger of pharmacists just paying lip service to the public health roles they would be paid for under the new contract's essential services.

Nicholas Wood: how do we 'sex-up' public health?

Pharmacists were often too busy dispensing to deal with public health problems in depth and they encountered a public that was not particularly interested in health messages.

"My question is – how do we enthuse pharmacists to engage in public health? In other words, how do we 'sex-up' public health in pharmacy?"

Mr Wood thought the contract's enhanced services would allow greater participation and would demonstrate to primary care trusts the important role pharmacists could play. The fact that pharmacists saw customers when they were healthy as well as ill was an important advantage.

Preventing bio-terrorism

Data from pharmacies could be a useful surveillance tool in identifying bio-terrorist attack, said Professor Rod Griffiths, president of the Royal College of Physicians' Faculty of Public Health.

Pharmacists could spot trends in symptoms, for example a sudden outbreak of double vision could indicate exposure to nerve gas. US pharmacies already carry out syndrome surveillance and this could be introduced in the UK with the right IT. NHS Direct, too, is geared to detecting sudden changes in the incidence of suspicious symptoms.

Professor Griffiths thought many health messages could be adapted to a pharmacy setting. Pharmacists had proved they could cope with challenging public health measures such as needle exchange schemes, where they had to deal with hazardous objects and difficult clientele.

"So we could consider using pharmacies for services we've not usually considered there before," he said. But one problem was – who would pay for the space and time?

Professor David Hunter, chair, UK Public Health Association, said the interface between the public health workforce and pharmacy is weak and undeveloped, yet pharmacists encounter key elements of public health every day.

There was a need to build on this and encourage the development of community-based partnerships in which PCTs were major players.

In future, pharmacies would have health promotion and lifestyle advice as a central focus but this could be extended to the wider determinants of health, for example pharmacies could become informal access points for debt advice and referring clients to social services.

Improving health through pharmacy

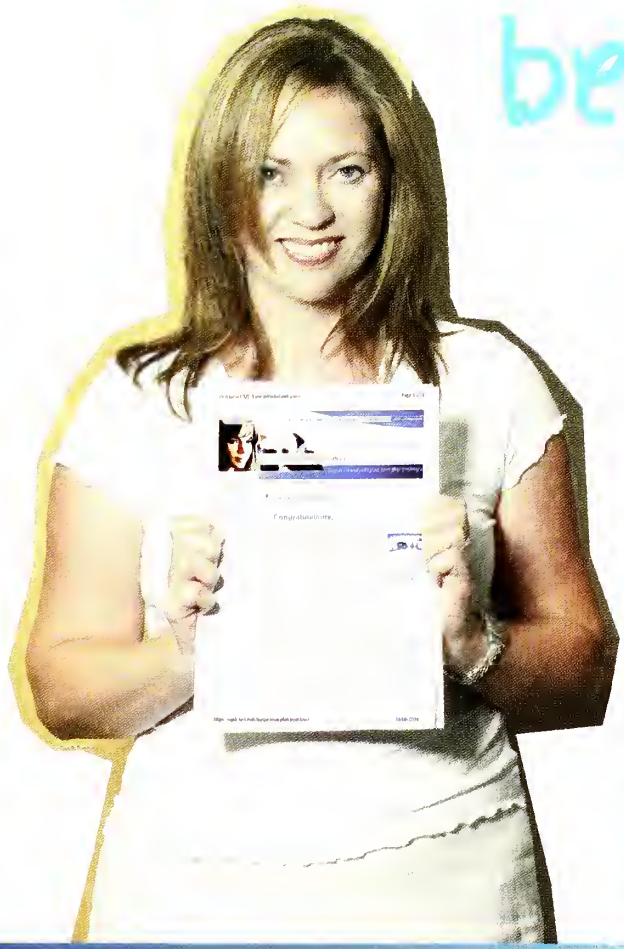
Jenny Griffiths, project leader, outlined work done on the draft strategy.

The 10-year strategy (2005-2015) will propose 10 key roles for pharmacy in public health, aiming for greater geographical coverage and more services than at present. Most pharmacists will continue to be wider public health workers, but some could register as specialists.

Another aim is to integrate pharmacy public health with the primary care team and take advantage of the GMS contract.

While much of the development will come under locally commissioned enhanced services, other sources of funding will need to be tapped into too.

My pharmacist said "If you're going to quit smoking, you better have a plan."



The Click2Quit Smoking Plan is a [illegible] programme designed to [illegible] support [illegible]

[illegible] Click2Quit Stop Smoking Plan, you'll be[illegible] before [illegible] to help [illegible] smoking [illegible]

NiQuitin CQ Nicotine

Customers can visit Click2Quit.com for their personal quit plan

Quittin' with NiQuitin

Quitin CQ 2mg/4mg Lozenge and Mint Lozenge **otine)** for relief of nicotine withdrawal symptoms during king cessation **Dosage:** *Adults only* 4 mg if smoke within minutes of waking. 2 mg if longer. Stop smoking completely eks 1 to 6, 1 lozenge every 1 to 2 hours (min. 9 max. day), weeks 7 to 9, 1 lozenge every 2 to 4 hours, weeks 10 2, 1 lozenge every 4 to 8 hours. Weeks 13-24, 1 to 2 nges per day only when strongly tempted to smoke. **ntraindications:** Non-smokers, those under 18, PKU, recent stroke, severe arrhythmias, unstable/worsening /resting angina, hypersensitivity. **Precautions:** Hypertension, peptic ulcer, severe kidney/liver impairment, phaeochromocytoma, hyperthyroidism, diabetes, cardiovascular disease, low sodium diet. Swallowed nicotine may exacerbate oral/pharyngeal inflammation, oesophagitis, gastritis, peptic ulcer. **Interactions:** Concomitant medication may need dose adjustment. **Side effects:** Depression, irritability, anxiety, insomnia, headache, dizziness, cough, cold. Nausea, hiccup, flatulence, GI disturbance, appetite change, oral irritation/ulceration, nightmares, restlessness, mood change, pharyngitis, thirst, taste/sensory disturbance, dyspnoea, respiratory disorders, rashes, itching, sweating, numbness, flushes, vascular disorders, halitosis, chest pain, throat swelling, leg oedema, pain, malaise, wakefulness, palpitations, tachycardia, tooth/jaw ache, nocturia. **Pregnancy/lactation:** Try without nicotine replacement therapy. Medical assessment of risk/benefit if necessary. **GSL PL:** 00079/0369, 0370, 0373 & 0374 **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack size and RSP:** 36's £8.99, 72's £17.49. **Date of last revision:** March 2004.

Comment from the Editor

Our question to pharmacists this week was: In light of the adverse media coverage for OTC simvastatin, how well has it been selling in your pharmacy?

"No movement, but we do stock it"

Howard Ryan, Sandwich, Kent

"Disappointing sales. It's a non-starter, price is one reason, the other is a case of people here buying their medicines to fulfil a need rather than to prevent illness"

Angela Garrett, Chester, Cheshire

"Disappointing sales; we're all geared up but we've only sold one. Lack of knowledge and cost seems to be keeping the customers away"

Stokes-Barrett, ton on Trent

On Tuesday the Government published its long-awaited White Paper, *Choosing Health* on public health for England.

The inevitable media leaks meant we already knew the headline details but it was, nonetheless, good to see the Government pledge to make better use of community pharmacies in tackling public health issues.

Earlier in the week, and with considerably less fanfare, England's chief pharmacist Jim Smith outlined the separate pharmaceutical public health strategy, which the DoH in conjunction with pharmacy bodies is aiming to launch next year. He said it was a huge opportunity for pharmacists to play a central role in public health, and highlighted the importance of building such a role into the new contract.

Pharmacists in Scotland and Northern Ireland might ask what all the fuss is about: public health is a central plank in the new Scottish pharmacy contract, while Northern Ireland has successfully been addressing local health inequalities through its Building the Community-Pharmacy Partnership. But in England, the Government must back its vision with funding to enable PCTs to commission services from community pharmacy, lest the Paper be seen as nothing more than headline grabbing election fodder.

Smoking and obesity, to name but two public health issues, already consume much o the NHS's resources and, if the NHS is to survive another 50 years, governments will have to champion the public health mantra of prevention. The end results will far outweigh the initial input.

Let us not look back in 10 years and rue the missed opportunity.

Pharmacists in Scotland and Northern Ireland might ask what all the fuss is about

Yourviews

Pharmacy Consultative Boards' national chairman Mike Smith gauges the tide of opinion on the new pharmacy contract

Grass roots reaction

The overall view expressed at the PCBs around the country was that the new contract should be welcomed. One pharmacist described it as "a wonderful opportunity to allow pharmacists to deliver the type of service to patients that they can be proud of", while another referred to the "tremendous opportunity for the profession which we must grasp".

There was a perceptible buzz of excitement at the meetings and most pharmacists declared the contract as offering a fair deal. But there is still much uncertainty about how it will work.

Specific areas of concern, which were flagged up, included:

- Have the PCTs got a full understanding of the new contract – and will they see it as a financial priority?
- There appears to be no way of actually comparing remuneration under the old and new contacts.
- How can we find the time?
- In future, the retained profit on purchase must be calculated in a fair and transparent manner.
- Uncertainty – there is a temptation to wait and see what happens.
- Accredited checking technicians are key to the implementation of the new contract, but how can we generate enough additional incon to pay for these?

Having had the feedback from all the PCBs now, I see that most pharmacists are more optimistic and enthused by the opportuniti

Although there is still some uncertainty about how parts of the contract will work, pharmacists have to be ready to face the challenge. Doing nothin is not an option. Prepare now – your staff, your premises, yourse

You can't afford to wait and se what happens. If the new contra is met with apathy, it will be dea in the water. We must get out there and do it.

TOPICAL REFLECTIONS

Hoping for new money for existing services

It is a common complaint that we always seem to be doing more for the same, or less, money and one that I have heard levelled at the new contract. This is something we will probably always have to deal with, as we continue to make efficiencies to manage spiraling script numbers and we launch new services without payment in the hope of future remuneration for a proven service. I am therefore cheered by news of a couple of things that we do for free and might yet be paid for.

As virtually all my patients receive their repeat medication on a 28-day basis the number of 'emergency' supplies I make is increasing. So much so that some patients try requesting an emergency supply of five days' medication every time they put in their repeat request form.

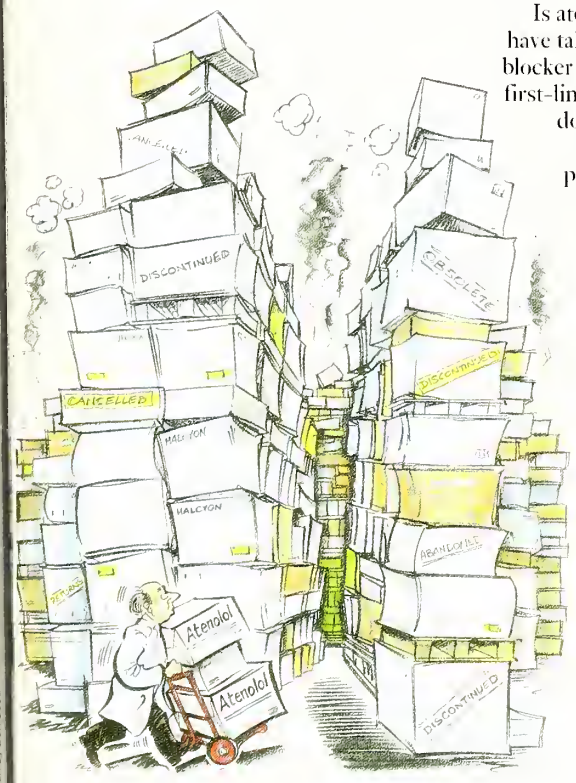
I am always careful to ensure that these supplies are justified, that the prescription arrives, and that this dispensed medication is subtracted from the prescribed quantity. And I always remind my patients to try and re-order their medication a little earlier next month. All this takes quite some time but realistically the only alternative is that patients go without their medication for a few days.

Ethically, I have no choice. My local Boots charges patients for this sort of supply and that keeps request down to a minimum but it seems particularly mercenary to me and against my ethos.

I'm not counting my chickens until they're hatched but am pleased to see that PSNC is negotiating under our new terms of service to allow us to make emergency supplies of up to 28 days and claim payment from the PPA for the quantity supplied. This will save my double dispensing and pay me for a service already provided. It will also prevent Boots' patients from going without medication for any length of time.

Payments for supporting patients with disabilities have not been finalised, but again this is a service I already provide to a limited number of patients for free. Popping tablets from foil strips into bottles for arthritic patients is not a demanding job but it's surely worth some payment. And compliance aids for patients in the community is definitely deserving of remuneration. Not all my patients will qualify as disabled but some will and I should be paid for supporting them.

The great atenolol hoax



Cartoon by Don Seed

Is atenolol the latest in a long line of drugs that have taken us all for a ride? Has this trusted old beta-blocker been masquerading as an effective modern first-line therapy for years when all along it has never done what it claimed on the PIL?

Last week's news that atenolol might not be a particularly effective drug (*see C&D, Nov 13, p34*), came as a shock. I dispense my fair share of the annual 16 million scripts for this drug and in my mind it ranks up there with aspirin and penicillin in terms of 'tried and tested'.

It must have been taken by millions of people over the years, so why has somebody only just discovered that it might not work?

I assume this was a reasonably rigorous trial for it to be published in *The Lancet*.

Although that was the journal that published the original MMR and autism study and it could have made another error of judgment, I think it unlikely.

Maybe atenolol is about to join the ever increasing list of drugs consigned to the pharmaceutical dustbin with the likes of Vioxx, Halcyon and thalidomide.

Perhaps it will survive the odd scare story or two, in the manner of Seroxat and Lariam.

Or is it simply that if any drug is studied for long enough and from the right angles none of them are quite as good as we first thought?

BPSA VOICE

Is there room for a new category?

British pharmacy students debated a new category of medicines at the 62nd BPSA annual conference earlier this year. This was just one of several discussions in the area of practice pharmacy. The conference unanimously passed a motion that there should be a new classification of medicines in which pharmacists are legally obliged to consult with the patient in order for a sale to be made. So-called 'pharmacist-only' medicines were also a topic of discussion at the recent UniChem convention in South Africa.

BPSA members believed that the potential risks of some over the counter products made a suitable case for a new pharmacist-only medicine category. Such a system would ensure that patients used medicines safely, effectively and in an appropriate way. Students commented that several reports such as *Which?* highlighted that advice on Pharmacy medicines is not always satisfactory and that the pharmacist is not always consulted.

Throughout the debate examples were drawn from a medicine classification system which incorporates pharmacist-only medicines in Australia. Concentrating on this country, it was stated that pharmacists already have to consult with patients before a sale can be made, using the example of emergency hormonal contraception.

With an increasing number of medicines being rescheduled from POM to P, other medicines such as simvastatin and omeprazole would need attention. In these cases, pharmacist-only medicines may go beyond a consultation for a sale and into the area of patient monitoring.

James Wood is president of the BPSA, the official student organisation of the Royal Pharmaceutical Society of Great Britain. He is a pre-registration trainee with the Co-operative Group Pharmacy in Huddersfield. E-mail, president@bpsa.com

Please e-mail your views to chemdrug@cmpinformation.com

There is still time to rethink...

During any change there is and will be controversy. It is healthy therefore to have a debate on concerns that the diverse group of pharmacists have. But also there is a need to recognise that good work done by all sides including PSNC. The developments with respect to branded generics could be interesting, as well as the introduction of IT and more money legitimised as necessary and covenanted. PSNC must be thanked for the efforts.

Community pharmacy is a diverse sector with diverse needs and ambitions. Failure to take these needs into account is unacceptable.

There is more covenanted profit from purchasing and so the global sum is supplemented by newly labelled monies. This in the long run must be a good thing for all parties. But, there are no new monies; just newly labelled monies.

The ministers used to shout that we will have 'a contract that will reward quality not quantity'. While there are improvements, which all pharmacists and others would welcome, there is no real extension in the range of services to be provided and developments are still in the gift of the PCTs who are struggling to balance the books in virtually all areas of the country.

There is a definite redistribution of monies from the bottom end towards the top, disadvantaging smaller contractors and particularly those dispensing fewer than 2,500 items a month. The changes to the qualifying criteria by indexing the thresholds is despicable and designed to drag more pharmacies into the death-trap. This was not a Government but a PSNC initiative and this aspect should be renegotiated.

These contractors will have a hard job convincing the PCTs that they must invest in those pharmacies and therefore the contractors and the LPCs representing them are being set up to fail. Last week it was reported that 7 per cent of all contractors dispense fewer than 2,000 items a month. It seems that this group of around 750 contractors would be more adversely affected than the rest.

While it is true that they will, like all contractors, receive more covenanted income than before, it is also true that after three years of the new contract their legs will be taken away from underneath them. We must not allow this cull to happen. No one is thinking of subsidies or handouts. But it is important that the 'score card' is fair to all. The so-called 'fair funding' is denied to 750 contractors and this is unfair.

More broadly, it is very interesting that Steve Dunn, group managing director of AAH, says that "pharmacists are being asked to sign up to a new contract which is demanding more work for the same money".

So at least he is agreeing with the NEL LPC that there is no new money. He also says that "pharmacists and the wholesalers are being asked to make considerable further investment to comply with the latest thrust of the NHS contract". Then he warns that 'there will be collateral damage'. Collateral damage is a euphemism for inadvertent casualties and destruction in civilian areas by military operations. This is a stunning piece of news as Steve Dunn is a leader with vision and deep understanding of community pharmacy and wholesaling finances.

The lack of a tool to compare the financial picture before and after the contract means that people are being asked to vote blindly and on faith. This is absolutely scandalous. Financial pictures are vital to enable each contractor to vote in an informed way. For democracy to work, people must have clear unambiguous information in reasonable time. It is not too late t provide tools that PSNC is happy with, but it is unhelpful to complain and produce no tools to help the contractors.

Finally what has happened to this year's pay increase? And whe is it going to be paid? In relation t this year's remuneration, what is the percentage increase and why has there been no public statemer about that to date?

The LPCs could commission their own ballot to ensure that various key aspects of the contra are put to the contractors to ensure that the contract is reshaped to reflect contractor opinion. There is nothing to stop them from doing this and lobbyi relevant bodies.

There is a need to rethink. There is an opportunity to listen and make the necessary compromises before the professi tears itself apart.

Hemant Patel,
North East London LPC

Zocor Heart-Pro: an alternative view

I wish to express my disagreement with the correspondent Robert Logan (*C&D, Nov 6, p18*) when he says we should be more pro-active in selling Zocor Heart-Pro.

I was amazed when I heard that this product had been granted an OTC licence without the prior provision of a suitable means for determining levels of HDL and LDL cholesterol in blood, and so no means of ensuring appropriate dosage. I was also disturbed that some of our elders and betters should see this as a great opportunity for the advancement of the profession of pharmacy.

Johnsons is attempting to scare the public into purchasing a potentially harmful product in an inadequate dose, to treat a condition they may or may not have, and who will then have no means of knowing whether or not the treatment has been successful. If they succeed in this, many people will be put at risk by believing that they are protecting themselves from the effects of high blood cholesterol levels when in fact they are not.

Surely we should be directing people whom we consider may be at risk to consult their medical practitioner so that they may have, if it is indeed needed, properly controlled treatment, for which they have already paid by way of national insurance contributions.

It would be beneficial to the public, and a step in the right direction for pharmacy, if licences were to be granted, for example, for the OTC sale of chloramphenicol or fusidic acid for the treatment of conjunctivitis, or trimethoprim for cystitis in adult females. Such acute conditions are readily diagnosed in the retail setting, and success or failure of treatment is equally readily apparent. Unfortunately, I suspe that the potential profit from su items would not be sufficient fo manufacturer to justify the cost obtaining an OTC licence. As another correspondent has said the same letters column, "the aspirations of a healthcare professional are not the same as those of a company".

F P Reader.
Horley, Surrey.

More letters on page 1

ContractQUESTIONS

Raj Patel, a member of PSNC's contract negotiating team, answers questions about the new pharmacy contract

1. What difference will the new PPRS arrangements make to my business?
Overall it should make no difference once the new contract funding arrangements come into operation. Under those arrangements, the £500 million retained purchase profits, based on the independent purchasing ability, is secured and adjustments will be made to ensure provision of that level of funding.

2. What guarantee is there that the increase in the number of prescriptions will continue and how will that impact on future funding?
Projections are that the increase in volume seen in recent years will continue in the immediate future. As it is explained in the new contract book, future volume increases will be taken into account in determining the adjustments to funding in future years.

3. How many of the PSNC committee own or work in pharmacies that dispense 2,000 items or fewer a month?
PSNC committee members are either regional representatives or representatives from other pharmacy organisations, working to secure a fair and rewarding contract on behalf of all contractors in England and Wales. The number of prescriptions dispensed by members of the committee are confidential to them and PSNC does not have this information. Twenty of the 31 members of PSNC are independent community pharmacy owners.

4. Why have we only been given three weeks to vote when the contract isn't being introduced until April 2005?
The new contract book was published on October 25 and the ballot closes on November 22. Contractors have had the opportunity to ask questions at any of the 28 roadshows held across England and Wales. In addition, substantial information has been made available on PSNC's website. PSNC believes that this is a sufficient period of time to digest the information on the new contract and vote in the ballot. Subject to a 'yes' vote, contractors will need time to prepare for the implementation of the new contract before its introduction on April 1, 2005. Therefore it is important that contractors are aware of the outcome of the ballot as soon as possible. In addition, a General Election is looming and PSNC wants to ensure that a new contract for community pharmacy is secured before a possible change of Government.

5. How many pharmacies (both multiples and independents) fall into the 2,000 items or less category?
Seven per cent of all pharmacy contractors will dispense fewer than 2,000 items next year. This figure includes ESPS pharmacies and those dispensing fewer than 1,100 items per month who do not receive the professional allowance today.

6. Why hasn't the exit payment been made available over the first three years of the contract, giving time for pharmacies to judge how their businesses are faring under the new system?
PSNC fought to gain agreement to exit payments for the first three years, but the arrangements set out in the new contract book were the best that could be negotiated.

7. Why have no regional differences been factored in, such as London weighting?
The joint DoH/PSNC cost inquiry did not show that costs were higher for community pharmacies located in London.
For more information on the cost inquiry see page 37 of PSNC's new contract book.

Ple@se e-mail your views to chemdrug@cmpinformation.com

New contract imposes burden but contains no new ideas

The new contract places an additional burden on contractors in the following manner:

1. Compliance support to disabled patients including aids, which requires investment of time and equipment.
2. Signposting is another time consuming activity.
3. Formal medicines use review.
4. Formal prescription intervention.
5. Consultation area.
6. Minimum dispensing support to receive practice payments.
7. Hours of opening will require pharmacies to stay open until 6pm instead of 5.30pm unless open six days a week.
8. Possible forced extension of opening hours if the PCT deems it necessary.
9. Competition through changes in control of entry.
10. Appropriate training to undertake essential service two (repeat dispensing).
11. Waste to be separated between public's unwanted medicines and pharmacy's own out-of-dates. Additionally, extra responsibilities placed in separating aerosols, CDs and liquids.
12. Recording of interventions.
13. Recording of PCT campaigns requiring advice.
14. Participation in annual surveys.
15. Repeat dispensing transition payment equivalent to about 5 per cent of total income. What is meant by 'transition' has not been explained.
16. Loss of £300m in the form of 'payments from PCTs' – this will disproportionately disadvantage most independents (*see panel*).
17. Loss of oxygen contract.

Individually the points above may not amount to much but together they become a mountain of burden.

Current payment, according to PSNC's contract prospectus, amounts to £1,666m to provide current services (£1,766m less £100m for repeat dispensing).

Essential services funding amounts to £1,669m less £100m for repeat dispensing, ie £1,569m, out of which PCTs might require contractors to fund disposal of unwanted medicines as it is a prerequisite to essential services. Yet under PCT responsibilities, there is no mention of PCTs being financially liable out of their budgets. This will probably come from the £300m allocated to PCT from contractors' purchase profit. Hence, contractors will be at least

An independent can buy item X for £5.00 and a multiple for £4.00. The *Drug Tariff* price is £7.00. If the *Tariff* price is reduced as suggested, say to £6.00, the outcome would be:

	Independent	Multiple
Original profit	£2.00	£3.00
Percentage of *DT* price	28.6	42.9
New profit	£1.00	£2.00
Percentage of new *DT* price	16.7	33.3
Loss of profit	£1.00	£1.00
Percentage loss of profit	50.0	33.3

In reality the multiples will 'persuade' manufacturers to make up the shortfall, who will in turn increase the price independents end up paying and so the effect would be even more worse for independents.

Ple@se e-mail your views to chemdrug@cmpinformation.com

£100m worse off. (This is going to pay for contractors' IT needs and advanced services.)

This figure will grow as the years go by, since the purchase profit, although recognised, has not been crystallised in an actual figure, nor has the precise method of working it out been made clear.

Now the question arises that, if the DoH can raid contractors' purchase profit today to the tune of £300m, what guarantee is there that this activity is not repeated in years to come? For the security of contractors, the purchase profit needs to be an actual figure, which can be substantiated with evidence in order to be protected and fairly distributed among all contractors and not just the bigger ones.

Considering that this was to be a 'new' contract, no new ideas have been forthcoming, such as:

- Contractors to be included in the NHS pension scheme like GPs, nurses and dentists.
- Limiting dispensing to a maximum of 28 days to reduce the financial burden of holding larger stock levels for contractors.
- All solid-dose manufacturers to be obliged to produce 28-day packs.
- Recognising difficulties in the metropolis in attracting and retaining support staff after training without increased financial incentives.
- Greater costs involved in running businesses like CCTV.

This is on top of other burdens placed by other sources like the RPSGB (SOPs and dispensing staff training), Medicines Act (requiring physical presence of pharmacist in pharmacy – what is the purpose of training counter staff if the easier tasks cannot be delegated?) and Disability Discrimination Act provisions.

The exit provisions are only for the first year. Why just the first year and why so meagre in its figure? Have the implications of a lease been considered, and what about employees' redundancy rights?

The 'new' contract is still linked to prescription numbers. This is in contrast to GPs, whose burden of managing repeat prescriptions will be reduced by pharmacists, on top of GPs having the option to opt out of providing 24-hour care.

Taking the above on board, only fools would okay such a contract, and there are plenty of them populating the 'profession of counting prescriptions.'

Jayvant Patel,
Hook End, Brentwood.

Pharmacist happy not to be in retail

As a pharmacist who qualified in 1958, and a subscriber to *C&D* for many years, and having read the articles in your November 6 issue, I am delighted I decided not to enter retail as a career.

My father was a retail pharmacist in Birmingham and I vividly remember sticking labels on bottles of nostrums.

But I think the new deal is rubbish and will result in the closure of many community pharmacies and an increasing tendency for people to use supermarkets.

All very bad in my view. Privately owned pharmacies in small communities provide a great service. They know their customers' needs. I accept the requirement for these pharmacies to extend their services into cholesterol testing, anti-smoking measures etc, and that they be paid by the Government for providing these.

Having voted Conservative all my life, I realise Mrs Thatcher started this trend. But I disagree with the removal of the basic practice allowance. The 2,000 items a month threshold is too high.

Not being involved in retail and thus not totally familiar with the discussions which have taken place, I appreciate some of my comments may not be material.

David R Williams,
Nottingham.

Prescribing information: Unguentum M is an ambiphilic topical preparation with emollient properties, which contains the high lipid content of an ointment but also has the water miscible characteristics of a cream. Contains: Purified water, white soft paratfin, cetostearyl alcohol, propylene glycol, glycerol monostearate 40-55, liquid paraffin,medium-chain triglycerides, sorbic acid, colloidal anhydrous silica, sodium hydroxide. Uses: Unguentum M has emollient properties and is recommended for the symptomatic treatment of dermatitis, nappy rash, ichthyosis, eczema, protection of raw and abraded skin areas, pruritus and related skin conditions where dry scaly skin is a problem, and as a pre-bathing emollient for dry/eczematous skin, to alleviate drying effects. It is also used as a diluent for various topical corticosteroid formulations where a lower strength preparation is required and as a general base for extemporaneous dispensing. Dosage and administration: A thin application of cream should be gently massaged into the skin three times daily or at appropriate intervals. When used as a protective cream Unguentum M should be applied sparingly to the affected areas of the skin before, or immediately after, exposure to a potentially harmful factor. Contra-indications, warnings etc: Unguentum M should not be used in patients sensitive to any of the ingredients Undesirable effects: None known. Package quantities 50g and 100g tubes, 500g tub and 200ml pump pack. Basic NHS cost: 50g £1.59, 100g £3.13, 500g £9.55, 200ml £6.19. Legal category: GSL. Product licence number: PL 00327/0115. Product licence holder: Crookes Healthcare Ltd, Nottingham NG2 3AA

Unconventional

It isn't usual for a lipid-based emollient ointment to be ambiphilic but Unguentum M is a little bit different.

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For symptomatic relief from eczema, nappy rash, dermatitis and other drying conditions in an easy to apply formulation.

Unguentum M. Works like an ointment, feels like a cream.

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In her third in a series of articles on vitamins and minerals, *Dr Ann Walker* explains that calcium has roles other than bone health

Calcium's role

THE COLLEGE OF PHARMACY PRACTICE

This course (module 1321), in association with multiple choice questions being published in *C&D* December 7, provides one hour's continuing education

Objectives

- To revise the functions of calcium in the body
- To know the main food sources
- To know the minimum requirements
- To be aware of the maximum safe levels
- To know which people are most likely to be deficient

Calcium is the most abundant mineral in the body, making up 2 per cent of body weight. More than 99 per cent of body calcium serves a structural function in bones; the remainder is vital for metabolism to ensure the normal function of clotting mechanisms, enzymes, nerves, muscles and heart. Feedback mechanisms hold blood levels of calcium constant, even at the expense of bone structure.

The UK National Diet and Nutrition Surveys (NDNS) show that many people have low calcium intakes, putting bone health at risk in old age. Women are especially affected and their lifetime reserves (peak bone mass) are lower, making them particularly vulnerable to age-related bone demineralisation and the development of osteoporosis.

Sources

Calcium is found in significant amounts only in a limited range of foods.[1] Milk and dairy products are excellent sources (*Figure 1*), being unmatched among everyday foods, apart from those fortified with calcium, such as soya milk, soya yoghurts and orange juice, but, unfortified, these are poor sources. Canned sardines and pilchards, eaten with bones, are also high in calcium, but are not eaten so frequently. Cows' and goats' milks have similar calcium contents, and low-fat dairy products are just as valuable calcium sources as whole-milk products.

For vegetarians, sesame seeds can be useful sources (six to 17 times higher than sunflower, quinoa or pumpkin seeds). Even so, 34g (just over 1 oz) of ground seeds are needed to provide the calcium found in a pot of yoghurt, and it is not such an adaptable food.

Vegetarians and vegans are often misled into believing that green leafy vegetables are good sources. Unfortunately, although containing calcium, these foods are high in water, which acts as a diluent. Hence, for example, a portion of cooked spinach, one of the richest of the vegetable sources, provides only a quarter of the RNI (reference nutrient intake), and a portion of broccoli far less. To achieve their daily calcium target, vegetarians should rely on regular consumption of tofu or calcium-enriched soya products, or take calcium supplements. Tap water may supply over 200mg per day, but this is unreliable as soft water provides virtually none.

Function

Bone is composed mainly of calcium and phosphate in the form of hydroxyapatite, but magnesium, manganese, zinc and vitamins C and K also have well established roles in bone health. Bone is a dynamic tissue, being continually remodelled by two cell types with opposing functions. These are the osteoblasts, which lay down new bone (accretion), and osteoclasts, which remove bone (resorption). The two processes proceed in tandem, resulting in a continual turnover of bone minerals. Even a slight enhancement of resorption over accretion can result in reduced bone density in the long term.

Calcium is a co-factor for many enzymes, and is required for blood clotting and by the immune system to form antibody–antigen complexes. A 'calcium pump' keeps extra-cellular calcium 1,000-fold higher than intracellular levels. However, stimulation of the cell opens

The average calcium intake for women is slightly lower than men. Most concerning is the 75 per cent of women in the 15 to 18-year age group who fail to reach the target of 700mg of calcium per day

Continued on page 22

calcium channels, allowing calcium temporary ingression into the cell to initiate cellular activity such as muscle contraction or neurotransmitter release.

Calcium homeostasis in the body is maintained by parathyroid hormone (PTH), calcitonin and vitamin D, which regulate intestinal absorption and urinary excretion of the mineral as well as bone mineralisation. Through this sophisticated feedback system a remarkably constant plasma level of ionised calcium is maintained.

Table 1: UK Reference Nutrient Intake (mg/day) for calcium

Age (yrs)	0-1	1-3	4-6	7-10	11-18	19-50+	during lactation
Male	525	350	450	550	1,000	700	
Female	525	350	450	550	800	700	1,200

Table 1 shows the RNIs for calcium set by the UK's Department of Health.[2] In setting calcium targets, national committees assess the world's literature and varying interpretations of the same data result in different dietary recommendations. Those set for the UK are modest, being lower than those for the USA, Australia and several European countries.

Calcium requirements are high during periods of growth. In the neonate, body calcium accumulates more quickly in relation to body size than at any other period. During childhood, growth is slower but, even so, more calcium per kg body weight is required than for adults. Because of the adolescent growth spurt, calcium needs rise again, accompanied by increased urinary loss. Hence teenagers with low calcium intakes are at risk of developing negative calcium balance (where output of calcium is greater than intake). This can result in poor bone mineralisation at the stage in life when it is crucial for the development of a good peak bone mass (reached in the early 20s). A high peak bone mass provides security against osteoporosis in later life, when calcium losses are inevitable. Although during lactation a higher intake of calcium is recommended, no increase above the adult recommendation is recommended in the UK for pregnancy, because absorption efficiency increases at that time. Nevertheless, adolescent pregnancy poses higher calcium demands because of continuing teenage growth.

Absorption of calcium requires vitamin D for the formation of calcium-binding protein in the intestine (*see C&D, Pharmacy Update, October 23*). Without it, calcium absorption fails and rickets will result in children or osteomalacia in adults. Normally, about 30 per cent of dietary calcium is absorbed, depending on the body's physiological state; infants absorb at the highest rate. Calcium from milk is well absorbed, because of its colloidal form and the facilitating presence of lactose, but absorption from vegetable sources is poorer.

Theoretically, there is potential hazard from excessively high intakes of calcium, but only in the presence of excessively high levels of active vitamin D (calcitriol), when calcification of soft tissues (calcinosis) becomes a risk. The UK Expert Vitamin and Mineral Group (EVM) has set a safe upper limit (SUL) of 1,500mg per day of calcium from supplements for long-term use.[3] In the USA the safe upper level for adults (including dietary sources) is 2,500mg per day.

Concerns that a high calcium intake increases risk of kidney stones are unfounded. Indeed, high intakes may even prevent stones.[4] Also, fears from epidemiological studies that a high intake of calcium or dairy products increases the risk of prostate cancer have also been allayed: a survey of nearly 4,000 men with prostate cancer concluded that although an intake higher than 2,000mg per day poses modest risk, no risk exists for more realistic intakes nearer the RNI.[5]

Magnesium nutrition can be jeopardised easily when magnesium intakes are low and high calcium intake can reduce magnesium absorption. For maximal absorption of both minerals, the Ca:Mg ratio in the diet should be 2:1. Ideally, therefore, magnesium should be included in calcium supplements for bone health. (*Magnesium is the subject of the next article in this series.*)

Surveys show that the average calcium intake of women is slightly lower than for men.

Figure 2 shows the percentage of women in the NDNS surveys with intakes lower than the RNI.[6] Of particular concern is the 15-18 year age group, where 75 per cent failed to reach this target.

[Note. Although the RNI covers the requirements of approximately 97.5 per cent of the population, among those not reaching the RNI will be people with requirements lower than the RNI. However, we have no way of knowing who these people are because techniques to measure requirements are not routine. Therefore, to ensure against deficiency, each person should use the RNI as his/her personal target.

Figure 3 shows the food groups that most contributed to the calcium intake of those surveyed. Two thirds of intake was provided by milk and dairy products plus cereals.[6]

Lower intake of calcium in the UK over the past 15 years has resulted from the move away from dairy products. The reasons are mainly fears that they are either high in fat and therefore calories or "mucus forming". Neither of these reasons have sound foundations: low-fat dairy products actually aid weight loss when used as part of a calorie-controlled diet, and there is no evidence of excess mucus formation. Indeed, Australian researchers found no difference between consumption or non-consumption of dairy products and mucus production in healthy

Figure 2: Percentage of women in NDNS surveys with daily calcium intake less than Reference Nutrient Intake of 700mg/day

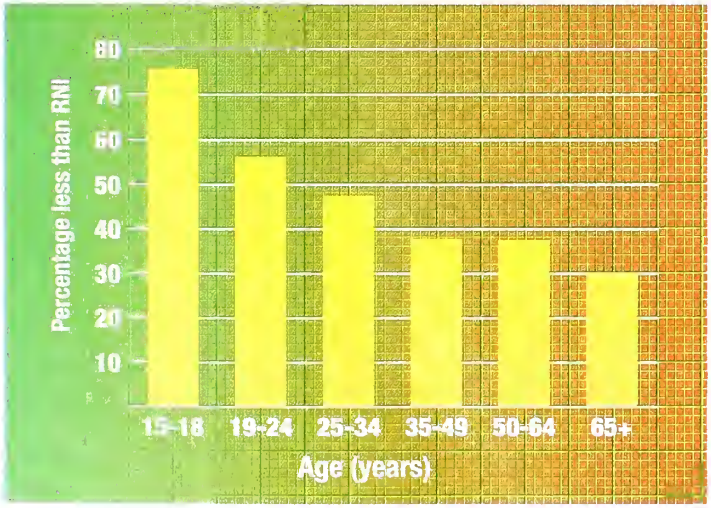
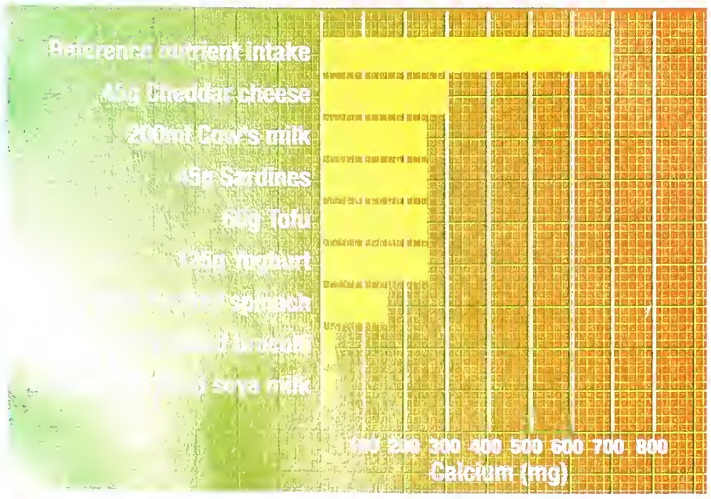


Figure 1: Food portion contributions to daily calcium intake



dults deliberately infected with
cold virus.[6]

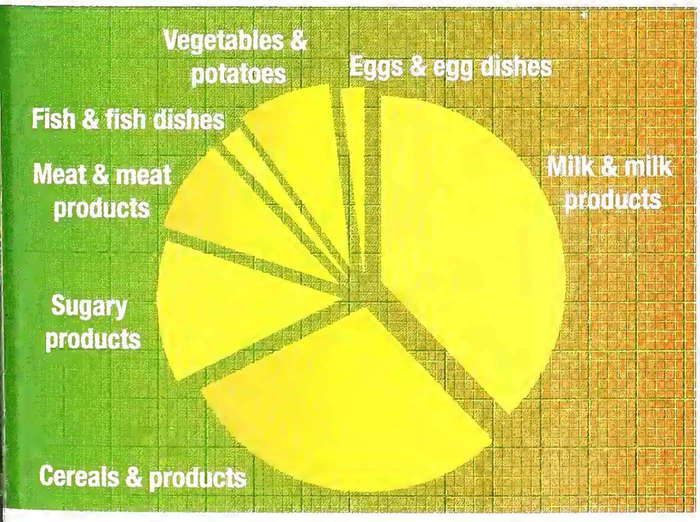
To reach the RNI for calcium, hree portions of the dairy products per day must be eaten *portion sizes as in figure 1*). For people on low- or non-dairy diets, alcium supplementation is necessary to reach this target, specially if canned sardines or esame seeds are not consumed on daily basis. However, because of he large quantities required, the necessary amounts cannot be ncluded in regular VMS upplements. Therefore, upplementary calcium needs to be taken on its own or, preferably, s part of a comprehensive "bone" formula.

Formulations of calcium upplements are not aimed at chieving optimal nutrition, but at overing essential (RNI) equirements. Nevertheless, numerous double-blind, placebo-controlled studies have shown hat calcium supplements at these evels, especially when used with vitamin D, prevent, slow or even everse the progress of osteoporosis, even when induced by steroids. Such supplementation appears to decrease the rate of bone removal, but its use must be regular and continuous or the benefit is lost.[8]

Calcium supplementation has other therapeutic applications: a large-scale double-blind study showed that it greatly alleviated symptoms of PMS (premenstrual syndrome).[9] Indeed, the authors concluded that the presence of PMS indicates calcium deficiency and increased risk of osteoporosis in later life. A meta-analysis of 33 studies showed that calcium supplementation can cause a significant, although modest, reduction in blood pressure, and several studies have linked calcium supplementation with a reduced risk of bowel cancer.[10]

Many people in the UK have inadequate intakes of calcium, especially teenage girls, who thereby increase their risk of osteoporosis in old age as a consequence of low peak bone mass. Apart from its role in bone health, a good calcium intake promises freedom from PMS for many women, as well as having useful hypotensive and anti-cancer effects. For further information on vitamins, minerals and supplements, visit the Health Supplements Information Service website at *www.hsis.org*

Figure 3: Percentage contribution of food types to average daily intake of calcium (sugary products include preserves, confectionery and soft drinks)



Terms to guide use of calcium

RNI – The reference nutrient intake is the daily amount of a nutrient that is sufficient to meet the mean (average) requirements of a given population *plus* two standard deviations, that is 97.5 per cent of a given population.
SUL – The safe upper level is the intake that can be consumed daily over a lifetime without significant risk to health.

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Dr Ann Walker is senior lecturer in human nutrition (part-time) at the University of Reading. She has undertaken many randomised clinical studies on the effects of supplements for a range of health problems and is author of numerous papers and several books. She is also a herbal practitioner and treats patients attending her clinic with a combination of nutrition and herbal medicine. She acts as an independent adviser to HSIS.

Actionplan

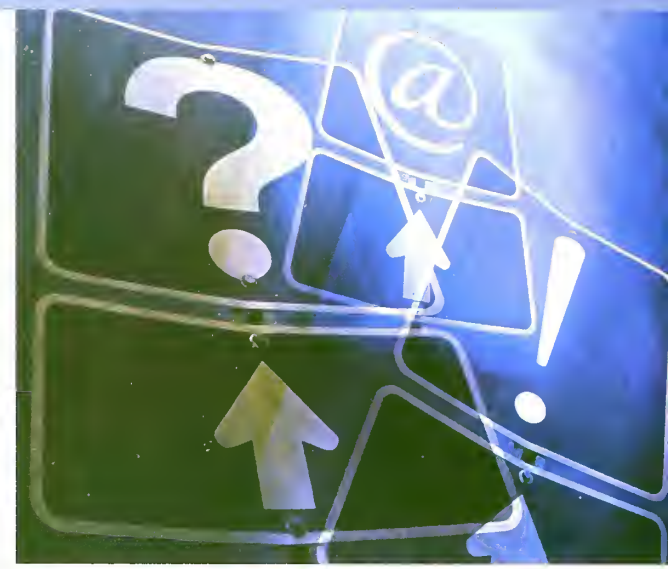
1. Relate the measurement of calcium intake in mg as quoted in this article to mmol as quoted in the *British National Formulary*.
2. The article mentions a few calcium sources. In your practice workbook list as many good food sources as you can trace. Use this list when discussing calcium intake with clients.
3. Consider which of these foods are suitable sources of calcium for vegans and vegetarians.
4. Find out the treatments for hypercalcaemia.
5. Revise the advice you give to patients taking bisphosphonates.
6. Look through your vitamins/minerals section. In your practice workbook list the products you will recommend as a source of calcium (think about magnesium as well). Make sure your medicines counter assistants are aware of this list.
7. Revise calcium supplementation as discussed in the *BNF* (*9.5.1.1*) and vitamin D (*9.6.4*). Also revise the vitamin D article in *C&D, Pharmacy Update, October 23.*

Ph[illegible] **Pharmacy Update** [illegible] the need to test. With [illegible] Pharmaceuticals, *C&D*'s [illegible] the multiple choice [illegible] (MCQ) paper to be inserted in the [illegible] week's CPP accredited [illegible] with those in the November [illegible]

● **Atrial fibrillation (1320)** ● **Vitamins/minerals part 3 (1321)** ● **Menstrual problems (1322).**

A telephone marking service offers independent verification of results – details on the monthly MCQ [illegible]
[illegible] Pharmacy Update can contact Mary Pebble on 017[illegible] 377269.

A question of **definition**



At the recent UniChem conference solicitor David Reissner tackled problems interpreting elements of the Government's proposed pharmacy reforms

In January 2003, the OFT recommended complete abolition of control of entry. In Wales, Scotland and Northern Ireland, devolved assemblies promptly asserted their new-found independence and rejected the OFT recommendations outright.

Because the 'necessary or desirable' test is enshrined in *The National Health Service Act 1977*, it would not be possible to remove it altogether without another Act of Parliament. Until parliamentary time is found for this the Government will have to achieve its objectives by creating exceptions to the 'necessary or desirable' test.

The Government's proposed reforms have three elements:

- New criteria of competition and choice.
- Exempting four types of application completely from control of entry.
- Reform and modernisation of the system.

I will examine in detail each of these three elements.

The introduction of competition and choice criteria does not fit easily into the way the courts have interpreted the 'necessary or desirable' test. PCTs and the Family Health Services Appeal Authority must assess the level of adequacy in the relevant neighbourhood. It is not a question of whether granting an application would result in 'improvement'.

The National Health Service Act gives the Government power to include in the regulations criteria for making decisions. In other words, it could direct PCTs and the Appeal Authority to take competition and choice into account when deciding whether or not an application should be granted. The problem with this is that an additional pharmacy is bound to increase competition and choice. If any [illegible] carefully, there is a coach and [illegible] would drive a coach and horses through sufficiently restrictive [illegible] *Health Service Act*. [illegible] purportedly made [illegible] the effect of nullifying the [illegible] test, it is extremely [illegible] challenge will be made. [illegible] that the reforms are outside the powers given by Parliament. Requiring PCTs to consider competition and choice could mean that every application is granted. The result would be abolition of control of entry through the back door, without an Act of Parliament.

In promoting the concepts of competition and choice, the Government said it was unduly restricting to place the burden of proof on applicants to satisfy a PCT that an application should be granted. As an alternative, it suggested that all applications would be granted unless a PCT considered that it would be "detrimental to the adequate provision of pharmaceutical services in the neighbourhood". This, too, is likely to result in almost all applications being granted. The proposed test of 'detriment to adequate provision' could mean objectors found themselves arguing about the financial effect on their businesses. PCTs and the Appeal Authority may have to examine the accounts of pharmacies and assess how they would be affected by the opening of an additional pharmacy. PCTs do not generally have the expertise to perform this exercise, and hearings, which currently take an hour or two, may in future last all day. This may be good news for lawyers, but not for those who have to make decisions or who are on the receiving end of decisions.

"It is probable that it will take a series of Judicial Review cases to clarify the new law"

In addition to introducing criteria of competition and choice, the Government proposes exempting four categories of applications from the 'necessary or desirable' test:

- Pharmacies in large shopping developments over 15,000sq m.
- Pharmacies that intend to open for more than 100 hours a week.
- Applications from members of a consortium to establish a one-stop primary care centre.
- Internet and mail-order based pharmacy services.

The proposal to free from control of entry applications by consortiums to establish one-stop primary care centres also raises many uncertainties. GPs and developers often rely on having a pharmacy to subsidise the cost of a development. Deregulation would provide certainty that an application would be successful. However, a great deal depends on the definition of a 'one-stop primary care centre'. The Government says such centres must be part of a PCT's written development plan or strategy. It proposes that they should, as a minimum, include "GP and related services, together with services provided by NHS trusts and community and other primary care services, such as dentistry, optometry, podiatry and physiotherapy, as well as a pharmacy". This is all very vague. The Government's *August Press* said any exempted primary care centre would have to offer services to around 18,000–20,000 patients – although this is not in the official announcement. Perhaps the Government will choose to avoid defining primary care centres and list them instead, as they do with out-of-town shopping developments.

A 'consortium' also requires definition. One definition proposed by the Government is 'a temporary grouping of independent firms or organisations, brought together to pool their resources and skills in order to undertake a particular project'. It would not necessarily include the owner of a pharmacy business. In other words, a consortium would not have the generally understood meaning in pharmacy of a group of local pharmacy owners banding together to run an NHS pharmacy. The Government envisages that the consortium members would include the NHS and venture capital companies.

According to the *NHS Improvement Plan*, the new regulations will be in force from the end of this year. It seems likely that, following changes to the 17-year-old control of entry regime introduced by Margaret Thatcher's government, it will take time before applicants, objectors and decision-makers have a clear understanding of the new requirements.

It is probable that, just as the courts were repeatedly called on to clarify the 1987 regulations, it will take a series of judicial review cases to clarify the new law. Not all the ambiguities and loopholes will be spotted at once. A musical hit of 1987, released by a group called Ferry Aid, was a version of *Let it Be*. Those who want control of entry and those who have sought abolition may all come to wish the Government had done.

Niaspan found to slow atherosclerosis

atients with atherosclerosis can op the disease progressing by sing prolonged-release nicotinic id with a statin, researchers nnounced at the recent American leart Association conference.

After a year of treatment, atients on Niaspan and a statin had little or no progression in their atherosclerosis, the researchers claim. By adding nicotinic acid, the researchers claim, atherosclerosis progression slowed by 68 per cent. In addition, a significant increase in HDL cholesterol was seen.

The study followed 200 patients already receiving a statin who were randomly assigned to nicotinic acid or placebo. Patients who received nicotinic acid were initially treated with 500mg daily, increasing to 750mg daily after two weeks, up to 1,000mg daily after a further two weeks. The recommended maintenance dose for Niaspan is 1,000 to 2,000mg daily. Of the patients who received the dual therapy, 3.8 per cent had a cardiovascular event compared to 9.6 per cent in the placebo with statin group.

Text in PILs is too small for some patients, study finds

Text in patient information eaflets is too small for those with npaired vision to read, esearchers from Glasgow have nnounced.

Patients with moderately good ght (6/18) were able to read the edication instructions, but about wo thirds of those with poorer ght (6/24 and 6/36) were unable o read the text. Nearly all the atients with 6/60 visual acuity ere unable to read the nstructions.

The researchers studied at what oint the 180 patients were no onger able to read the anufacturer's information on the medication without magnification. All of the patients, average age 70, had some vision impairment including cataract, glaucoma and macular degeneration. Patients were allowed to bring the bottle closer to them to read, and the time to read the label was recorded. A time of over 30 seconds was recorded as "reading with great difficulty".

Patient information leaflets are difficult to read because the text is too small, researchers in Glasgow have found

The authors say text in Arial font at point 22, which is approximately three times the size normally used, would meet everyone's needs. It should be distributed with medication "when the patient is found to have a best distance visual acuity of 6/24 or less, particularly if the patient is elderly".

"It is common for patients to leave a consultation without remembering what was discussed, including how to take their medication," say the authors.

For more information:

British Journal of Ophthamology 2004; 88: 1541-1542

Scriptlines

Taxotere

The European Commission has approved Taxotere (docetaxel) injection concentrate for use in combination with prednisone in men with androgen-independent metastatic prostate cancer.

The decision is based on trial data which showed docetaxel reduced the risk of death by 24 per cent in men with this specific cancer. Common side effects were alopecia, fatigue and nausea.

For more information:

www.sanofi-aventis.com

Alliance acquisitions

Alliance Pharmaceuticals will assume responsibility for the distribution of certain products from CollaGenex International and Unigreg from November 15.

Periostat (doxycycline 20mg) collagenase inhibitor for periodontitis will be transferred form CollaGenex International to Alliance. Forceval Capsules, Junior Capsules and Protein Powder, Gregoderm and Uniflu with Gregovite C, will transfer from Unigreg. All products will continue to be in their original livery until Alliance branded packaging comes through the production and distribution channel.

For more information:

Alliance Pharmaceuticals
Tel: 01249 466966

Midrid in 30s

Manx Healthcare has launched a 30-capsule pack of Midrid (isometheptene mucate 65mg and paracetamol 325mg) for the treatment of migraine.

For more information:

See Price List supplement

Moxonidine generics

Generic versions of moxonidine have been launched by APS, Alpharma, Focus, Generics UK, Genus, IVAX, Pliva Pharma, Ratiopharm, Sandoz and Tillomed Labs.

All companies have launched moxonidine tablets in packs of 28 and 200mcg, 300mcg and 400mcg doses except Ratiopharm (200mcg and 400mcg only).

For more information:

See Price List supplement

Lipitor SPC update

Pfizer has updated the Lipitor (atorvastatin) SPC to include information on the concomitant use of grapefruit juice.

It states grapefruit juice contains CYP3A4 inhibitors and can increase concentrations of drugs that are metabolised by this enzyme. A 240ml glass of grapefruit juice raised atorvastatin levels by 37 per cent. Large amounts of grapefruit juice (over 1.2 litres daily for five days) raised atorvastatin levels. Pfizer does not recommend patients should consume large quantities of grapefruit juice while taking atorvastatin.

For more information:

http://emc.medicines.org.uk

Clarithromycin generics

APS and Generics UK have launched clarithromycin tablets 250mg and 500mg in packs of 14.

For more information:

See Price List supplement

Breast kit enhances touch

Good for Health is launching a reusable breast self-examination pad into UK pharmacies. The product has already been successfully launched in the USA and Australia.

Liv Kit is designed to encourage women to make breast self-examination part of their regular routine.

The pad is made from two sheets of a soft, transparent, latex-free polyurethane filled with a small amount of non-toxic lubricant.

It enhances touch and allows the fingers to glide easily across the breast tissue, reducing friction between the hands and the skin.

The kit also includes an illustrated breast health booklet to chart self-examinations and a velvet drawstring pouch for storage of the pad.

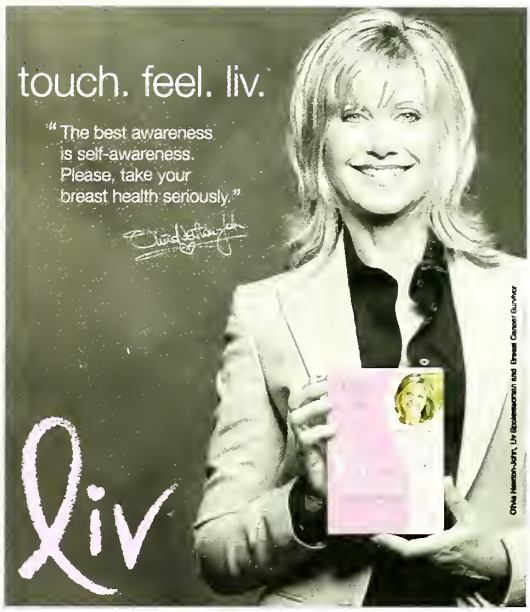
The product is supported and endorsed by Olivia Newton-John who has suffered and survived breast cancer.

Five per cent of sales will go to Y-Me – a US breast cancer charity.

A four-pack dispenser is available for pharmacies.

Price: £24.95

Pip code: 310 6440
Good for Health
Tel: 0870 225 2022



TV

Sponsored by

Accu-Chek: Sat
Askit Powders: GTV, C4, five
Benylin All areas
Bisodol: Sat
Blistex: GMTV, Sat
Calpol: All areas except U, GMTV
Clever White: GMTV, Sat
Horlicks: B, G, Y, C, TT, C4
Kool'n'Soothe: All areas except C4, five
Kool'n'Soothe Migraine: All areas except C4, five
Lucozade Energy: All areas except U, CTV, GMTV
Meltus: five, GMTV, Sat
Multibionta: C4, Sat
Nytol: All areas except U, GMTV
Olbas for Children: five, GMTV
Olbas range: five, GMTV, Sat
Scholl Party Feet: C4, five, Sat
Strepsils: All areas except U, GMTV
Sudafed: All areas except U, GMTV
Ymea: G, Sat
Zovirax: All areas except U, CTV, GMTV

...e for next week: **Ibuleve** – window, **Ibuleve** – in-store, ... life ... dispensary

...der, C-Central, C4-Channel 4, Five-Channel 5, ...TV-Channel Islands, G-Granada, GMTV-Breakfast ...-Grampian, HTV-Wales & West, LWT-London Weeken... Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tee... U-Ulster, W-Westcountry, Y-Yorkshire

Detox patch is under your feet

Waveney Health is launching a Japanese detox patch that is applied to the sole of each foot.

Simply Detox is claimed to absorb accumulated harmful toxins and waste matter from the body. According to the distributors, the patch can be used as a pick me up whenever people feel run down.

Based on the principles of Eastern medicine, the patch contains organic agaricus mushroom, the mineral tourmaline and Brazilian eucalyptus.

The distributors say that, like reflexology, the detox treatment associates areas of the feet with specific parts of the body. If the foot patches are used for at least seven days, the colour of the waste material should change from a caramel brown colour to a lighter grey colour depending on the amount of waste matter removed.

It is recommended that the patch is used while asleep. It should not be used during pregnancy or breast-feeding or on children under seven.

The launch will be supported by a £50,000 advertising campaign in health magazines until March 2005.

Price: £17.99

Pack size: 10 patches
Waveney Health
Tel: 0870 2426035

Essential Information
Product Name: Zocor Heart-Pro® 10mg tablets. **Presentation:** Peach-coloured, oval-shaped tablets containing simvastatin 10mg. **Indications:** To reduce the risk of a first major coronary event (non-fatal myocardial infarction and coronary heart disease (CHD) deaths) in individuals who are likely to be at moderate risk (approximately 10-15% 10 year risk of a first major event) of CHD. **Dosage and Administration:** Take one 10mg tablet daily at night. Not recommended for paediatric use. **Contraindications:** Hypersensitivity to simvastatin or any of the excipients; previous history of muscular toxicity with a statin or fibrate; individuals already taking prescription cholesterol lowering drugs; concomitant administration of potent CYP3A4 inhibitors (e.g. itraconazole, ketoconazole, HIV protease inhibitors, erythromycin, clarithromycin, telithromycin and nefazodone); active liver disease or unexplained persistent elevations of serum transaminases; pregnancy and breast-feeding; women of childbearing potential. **Precautions:** Zocor Heart-Pro® is not intended for individuals who are known to have: existing coronary heart disease, diabetes, history of stroke or peripheral vascular disease, familial hypercholesterolaemia. Individuals with hypertension should consult their doctor before undertaking treatment. Individuals with a fasting LDL-cholesterol level of 5.5 mmol/l or greater should consult their doctor. All individuals must be advised of the risk of myopathy and told to stop taking Zocor Heart-Pro® if they experience unexplained generalised muscle pain, tenderness or weakness. People aged >70 years or with hypothyroidism, renal impairment, personal or family history of hereditary muscle disorders should not take Zocor Heart-Pro® except on medical advice. Product should be used with caution and under medical supervision in people who consume substantial quantities of alcohol and/or have a history of liver disease. If treatment with itraconazole, ketoconazole, erythromycin, telithromycin or clarithromycin is unavoidable, therapy with Zocor Heart-Pro® should be suspended during the course of treatment. Concomitant use with potent inhibitors of CYP3A4, e.g. ciclosporin. Individuals with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine. **Side Effects:** Most commonly reported side effects were: abdominal pain, constipation, flatulence, asthenia, headache. The following side effects have also been reported: anaemia, paraesthesia, dizziness, peripheral neuropathy, dyspepsia, diarrhoea, nausea, vomiting, pancreatitis, hepatitis/jaundice, rash, pruritus, alopecia, myopathy, rhabdomyolysis, muscle cramps, myalgia. Apparent hypersensitivity syndrome has been reported rarely. Increases in serum transaminases, alkaline phosphatase and serum CK levels. **Legal Category:** P. **PL Number:** PL 13249/0039. **PL Holder:** Johnson & Johnson•MSD Consumer Pharmaceuticals, High Wycombe, Buckinghamshire HP10 9UF, UK. **Packaging Quantities:** 28 tablets. **Price:** £12.99 (RRP). **Date of Preparation:** May 2004.

Many of your male customers have no idea they need your help.

But they'll thank you for it.

ow, you can do more to help customers like him:
len over 45 who simply don't realise that they are at moderate risk of a heart attack.
ow, as well as giving them good advice on heart health, you can get them to take positive, preventive ction. When you find that a customer could be at moderate risk, that's a 1 in 10 to 1 in 7 chance of a eart attack in the next 10 years, you can give them the good news that taking Zocor Heart-Pro® can educe their heart attack risk, for example, by about a third over 3 years. Their risk stays lower as long s they continue to take Zocor Heart-Pro®. We've given you the tools to identify customers at moderate sk, so that you can supply them with Zocor Heart-Pro® without a prescription, as part of a healthy eart programme. Together, we can start saving lives.

HHP Healthy Heart Programme
w.heartpro.co.uk

For further product information visit zocorheartpro.co.uk
or call our pharmacists' support line on 0800 032 8258

Johnson & Johnson · MSD
CONSUMER PHARMACEUTICALS

Frontshop

Sudafed aims to unlock the senses

Pfizer Consumer Healthcare is backing Non-Drowsy Sudafed Congestion Relief with a £3 million national TV campaign throughout the winter season.

On air from November 22, the campaign is designed to appeal to a wide target audience to encourage uptake and trial.

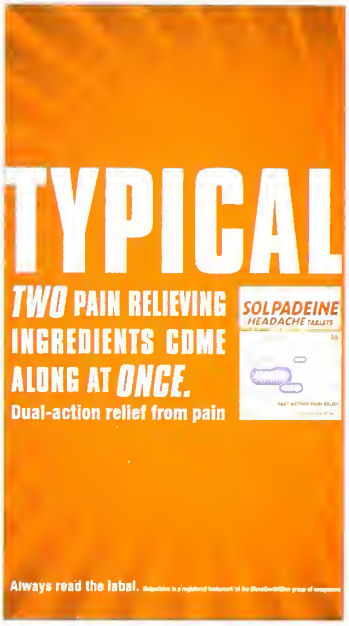
The new commercial features the message 'Unblock your nose, unlock your senses', highlighting how our sense of smell can affect our moods, personal interaction, sense of taste and overall wellbeing.

The TV advertising will be reinforced by a poster campaign designed to appeal to a slightly older audience in London, Manchester, Glasgow, Bristol, Liverpool and Southampton.

Unblock your nose. Unlock your senses.

Contains Phenylephrine hydrochloride

For more information:
Pfizer Consumer Healthcare
Tel: 01304 616161



Solpadeine makes headway on the buses

Solpadeine Headache is the focus of a £360,000 poster and bus-side campaign running until the first week in December throughout the London area.

GSK's campaign features advertisements that focus on the product's paracetamol and caffeine combination which provides dual action relief.

The advertising has a striking yet simple message: 'Typical. Two pain relieving ingredients come along at once' followed by 'Dual-action relief from pain'.

For more information:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Internet

Heart advice

Johnson & Johnson.MSD has launched a Zocor Heart-Pro healthy heart programme website. The site is designed to support and advise consumers who wish to reduce their risk of heart attack. Consumers are offered a tailor-made service that provides personalised lifestyle advice, as well as feedback on the steps they are taking to improve their heart health.

For more information:
www.heartpro.co.uk

Healthy read

Understanding Parkinson's Disease is the latest addition to the Family Doctor series of health information books produced with the BMA. Written by consultant neurologist Professor Tony Schapira, the book is designed to help people understand the symptoms and disabilities caused by Parkinson's disease. It covers self-help measures and latest drugs used in the treatment of the disease.

Price: £3.50
Pip code: 303-4782
Family Doctor Publications Ltd
Tel: 01202 668330

At your fingertips

Kent Cosmetics is widening the distribution for its Dutch Trind nail care system in UK pharmacies. The range comprises six products for the nails and hands – Cuticle Remover, Cuticle Balsam, Nail Magic Buffer, Nail Balsam, Nail Repair and Hand Repair. A merchandising unit is available to display all six products together.

Price: from £2.95 for Nail Magic Buffer to £8.95 for Nail Repair
Kent Cosmetics Ltd
Tel: 01622 859898

Female filmgoers are target of Nivea campaign

Beiersdorf is sponsoring *Bridget Jones 2: The Edge of Reason* in an attempt to boost Nivea's appeal to the film's predominantly female audiences.

The company says the initiative is designed to improve the brand's *joie de vivre* ratings by focusing on the fun in life.

The brand is also linked to the film in women's magazine advertising and on cinema posters and leaflets until January. The advertising focuses on Nivea Age Reversal and Fresh Deodorant.

The campaign directs consumers to the Nivea website where they are asked to tell their love life tales. Prizes include a skiing trip to Austria where the winner can stay in the same hotel as Bridget.

For more information:
Beiersdorf UK Ltd
Tel: 0121 329 8800

Steam Therapy

Steam therapy in the treatment of colds, sinusitis and other upper respiratory ailments has a long tradition and provides fast relief

Vapour inhalation as a treatment for congestion-related conditions is found in every country of the world. Often, this can simply be by inhaling the steam from a pot of boiled water, often with a towel draped over the patient's head to confine the vapour.

In recent years more and more people world-wide have become aware of the need for home humidification in high, dry areas and in countries where central heating or air conditioning dries out indoor air. Humidifiers and proper humidity help people breathe better, sleep better, improve the complexion and relieve congestion-related symptoms, such as those associated with sinusitis, hay fever, or colds and flu.

For years, doctors have debated how best to treat symptoms of congestion-related conditions. Today, more and more sufferers are using Grandma's remedy – all-natural steam – with the use of an inhaler. Warm moist air is steadily applied to the nose and throat to thin the mucus and help drain sinuses. Directly applying moisture to the noses and throat increases its therapeutic effect for quick relief of sinus, nasal and chest congestion, coughs and parched throat.

Steam inhalation is fast-acting and doesn't have side effects such as drowsiness or rebound congestion associated with some medications. It is ideal for use when medication has worn off, but it's too soon to take another dose. Let's look at the three main causes of congestion-related symptoms, their duration and treatment.

Sinusitis

Often a complication of a cold or other viral infection, or an allergic reaction, sinusitis develops when the sinuses – air-filled cavities located around the nose and eyes – become congested and inflamed due to bacterial infection. When this happens, air gets trapped, pressure builds, and bacteria multiply, causing infection.

Symptoms can include a stuffy nose, sore throat, cough, diminished sense of smell, headache, and toothache. Sinus pain lasting for more than three days may suggest sinusitis so should be referred to the doctor.

Antibiotics may be necessary to control bacterial infection, while a decongestant (check it is suitable for the patient) will help reduce mucus, and keep sinus drainage passages open. Breathing steam directly into the nostrils and throat to thin mucus and help drain sinuses.

Hay Fever

In an effort to rid itself of allergens such as pollen or dander, the body's immune response causes inflammation and swelling of the lining of the nose and sinuses. This results in violent sneezing, nasal congestion, difficult breathing and other respiratory symptoms as well as watery eyes. Breathing in steam can help open up nasal and sinus passages and reduce symptoms naturally.

Cold

The common cold is the most common upper respiratory disease. A cold is caused by viruses in the nose and throat, which are spread through direct contact or when the infected person talks, sneezes or coughs.

Symptoms include a runny nose, nasal congestion, sneezing, and a sore, scratchy throat. Sometimes there iwll ba cough or a slight fever, and fatigue.

Colds usually last between one and two weeks. Smoking may prolong the virus. Drink lots of fluid and get plenty of rest to help speed recovery. Fluids help loosen mucus and clear nasal passages. Breathe steam directly into the nose and throat for soothing relief of nasal and chest congestion, coughs and parched throat.

Don't forget to wash your hands often, and don't touch your eyes, nose or mouth after being around someone with a cold, or in a public place.

PHARMACY FINANCE 7

Property

Should you go for

This is the seventh of a series of 10 monthly articles by Anne Hutchings, and sponsored by Nucare, which will be published in book format next year

Sarah Kranz

[illegible]

Pharmacists selling their business often also own the freehold business premises and are flexible about selling the freehold or creating a lease. Faced with a choice, what is the best option?

Freehold or leasehold?

The issue may be dictated by cash flow and loan facilities. However, if you are able to choose, consider:

- the overall cost of the property, including stamp duty, legal fees and VAT (if any)
- current interest rates and your view of future changes
- your view of future appreciation of the property
- future maintenance costs
- terms on offer for a lease, including length and rent reviews.

Prepare a comparison of costs showing the cost of purchasing the freehold versus the cost of renting the property.

When weighing up the costs of freehold versus leasehold don't forget to allow for the initial costs in your cash flow such as legal fees, survey, stamp duty etc.

[illegible]

It is usual to negotiate a lease for at least the length of time for which you will have business loans; in fact the banks will expect this. It is important to use a solicitor who deals with commercial property and ask them to quote a fixed fee wherever possible.

If you are obtaining a lease [illegible] the pharmacy vendor, [illegible] room for negotiation [illegible]llowing: [illegible] rent reviews [illegible] try and [illegible] terms of the [illegible] the landlord [illegible] ver to the [illegible]

The next [illegible] to consider is [illegible] name the premises should be in. If you are a sole trader or partnership, the property, whether freehold or leasehold, will normally be in the names of the individuals. If you are trading through a limited company, then you have a choice of putting the property in the company name or the individuals' names.

If the premises are leasehold, I would put them in the company name as there will be no real advantage in having the lease in your own name. There will be less administration if the lease is owned by the company. If, however, you are buying the freehold, generally I would advise the purchase to be in the individual's name(s) and for the company to pay rent to the individual(s). This also gives more flexibility when you come to sell the business in the future. It is worth looking at some of the tax consequences of owning the property individually versus owning it through a company.

Premises owned by the pharmacist

A proper lease should be drawn up between the pharmacist and his/her company. This should be for a market rent and have the usual commercial clauses inserted. The company will pay the rent to the pharmacist and receive a tax deduction for the payments. The pharmacist will be liable to income tax on the rent received less any business expenses. The expenses will include loan/mortgage interest, which can often wipe out most of the tax liability for the individual. The main advantages from a tax point of view are: it is a way of getting money out of the company without any national insurance liability for the pharmacist. You can of course take money out of the company without national insurance by taking dividends, but the Government imposed an additional tax on this last year, which affects many small companies. Nobody knows what further changes may be introduced in the future to increase tax on dividends.

When the property is sold, if it has been owned by an individual it should qualify for business asset taper relief. Companies do not receive taper relief. The taper will significantly reduce any tax on the property disposal. Taking a simple example, Ben purchased freehold premises for £150,000 in April 2000. These premises were sold in December 2004 for £250,000.

A) If the premises were owned personally by Ben his tax liability would have been approximately:

Sale proceeds	£250,000
Purchase price	£150,000
Net gain	£100,000
Business asset taper relief 75%	£75,000
Taxable gain	£25,000

Tax assuming Ben is liable at 40% £10,000

B) If the company owned and then sold the premises the tax position would have been:

Sale proceeds	£250,000
Less: purchase price	(£150,000)
Less: indexation allowance estimated	(£16,000)
Taxable gain	£84,000

Company tax payable at 19% assuming total taxable profits and gains are under £300,000 £15,960

Not only is the company tax more than Ben would pay as an individual but if Ben wants to take the money out of the company he will have a further ta[x] liability which would be between about **£8,000 and £21,000** depending on the method by which the money was extracted.

There is another, tax efficient

taxes

leasehold, freehold or buy to let?

way of buying the business premises. Consider buying it through a pension scheme. If you are self employed you would need a self invested personal pension (SIPP), if you trade through a company you would use a small self administered pension scheme (SSAS).

The company will pay a market rent to the SSAS. This rent will be an allowable expense for the company but will not be taxable in the SSAS. In addition, any capital growth in the property accrues tax free in the SSAS.

Investment properties – buy to let

Buying property – don't overlook stamp duty in your budget. Stamp duty is payable on residential property at the following rates:

Purchase price	Stamp duty Rate
Under £60,000	0%
£60,001- £250,000	1%
£250,001-£500,000	3%
Over £500,001	4%

If the property you are buying is just over a stamp duty threshold try negotiating a proportion of the price for fixtures and fittings to bring it under the threshold. For example, if the property is priced at say £254,950 and included in the price are carpets, curtains and various furnishings, by agreeing that the cost of these items are £5,000 this will bring the value of the property down to £249,950 and reduce the stamp duty rate from 3% to 1%. In this example the stamp duty saving would be £5,149. The Inland Revenue does tend to look at cases which are close to the threshold so any apportionment to furnishings etc should be realistic.

A question I am often asked is whether property should be purchased in the individual's name, joint names with a partner/spouse or through a limited company.

As a general guide, if you only intend to own one investment property I would purchase it in an individual's name. It is not usually worth setting up a company with all the ongoing accounting and compliance costs for one property.

Purchase tip

It may save you tax to buy the property in the name of your partner/spouse if that person has a low income.

Joint ownership with you and your partner/spouse is another alternative, which can work very tax effectively in the right circumstances.

Another advantage of joint ownership is when you come to sell the property. You will both be entitled to the annual capital gains tax allowance, which is currently £8,200, and the balance will be taxed at your respective tax rates.

Mr Jones owned a buy to let property, which produced a taxable gain of £60,000 when he sold it. His other taxable income was £40,000, making him a 40% taxpayer. His capital gains tax on the property will be:

Taxable gain	£60,000
Less annual exemption	£8,200
Amount on which tax is payable	£51,800
Tax at 40%	£20,720

If instead Mr & Mrs Jones had owned the property and Mrs Jones had no other income the tax position would be:

Taxable gain	Mr Jones £30,000	Mrs Jones £30,000
Less annual exemptions	£8,200	£8,200
Amount on which tax is payable	£21,800	£21,800
Tax	£8,720	£3,209

Therefore, in this example the overall tax saving with joint ownership is £8,791.

Purchasing properties through a limited company

Advantages of a company

- Company tax rates are lower than those for individuals. As long as the profits are left in the company, there will be a tax saving. This may be useful if you are looking to reinvest all the profits into more properties.
- If you are only liable to tax at the basic rate, the dividends can be taken (after company tax) without any additional personal tax liability.
- Limited liability is a safeguard against the unknown if you can persuade your mortgage lender to provide finance without asking you to guarantee the funds.

Disadvantages of a company

- There will be fewer choices of lenders and this may mean that you end up paying a higher rate of interest than you would if the loan was for you as an individual.
- You will have additional costs for accounts preparation and tax work to comply with all the legislation.
- If you wish to draw a salary from the company you will need to operate a PAYE scheme – more administration and cost.
- From a tax point of view, it is expensive to have properties in a company because when they are sold the gains will be taxed twice. The company will pay tax on the profits and if you then wish to take the money out of the company you will face an additional tax charge. A better alternative would be to sell the whole company by selling the company shares. You will then only pay tax on the gains once. In reality it may be difficult to find someone who wants to buy your ready-made portfolio of properties.

There is no simple formula for establishing the best way to acquire either business or investment property. Each set of circumstances needs to be evaluated on its own merit.

Anne Hutchings, Hutchings & Co specialist accountants and tax consultants for retail pharmacists tel: 01494 722224 www.pharmacyexperts.com

Shipman impact

In its response to the Shipman Inquiry's proposals for CD reform, the RPSGB highlighted the impact on community pharmacy. **Fiona Salvage** looks at some of the key points


Dame Janet: fourth report looked at tighter regulation of Controlled Drugs in the community

In July last year, chairwoman of the Shipman Inquiry Dame Janet Smith published her recommendations for the regulation of Controlled Drugs in the community.

This was the fourth stage of the Inquiry, which focused on how Harold Shipman was able to obtain large quantities of Controlled Drugs and the recommendations contain many implications for future pharmacy practice.

Last week, the Royal Pharmaceutical Society published its response to Dame Janet's recommendations and highlighted the likely impact on community pharmacy.

Report's recommendation: To create a CDs inspectorate comprising small multidisciplinary teams of pharmacists, doctors, inspectors and investigators, operating regionally but co-ordinated nationally. It would inspect pharmacies and surgeries, and supervise CD destruction. It would scrutinise prescribing data for private and NHS CD prescriptions.

RPSGB response:

The Society recommended the inspection and monitoring of CDs should extend to all health professionals and establishments where CDs are supplied or administered.

It added the RPSGB's inspectorate should be centrally involved in the development of multidisciplinary CD inspection, as it already has the professional expertise.

The RPSGB said its inspectorate could extend its enforcement activity both within registered retail pharmacies and to other establishments, but said resources would be needed.

A medical practitioner's entitlement to prescribe or administer CDs should exist only if they need to do so for 'actual clinical practice' in which they are engaged. For the vast majority of doctors, this need will be obvious. A practitioner who wishes to prescribe CDs may, where the need is not obvious, have to justify the need when they apply for a special CD prescription pad.

The Society supported the requirement for 'actual clinical practice' to entitle practitioners to prescribe CDs and recommended implementation of a system, updated daily, to permit a pharmacist to confirm that a practitioner was 'licensed to practise'. However, adequate systems will need to be in place 24 hours a day, seven days a week, to allow pharmacists to confirm a practitioner's registration status and competency to prescribe CDs.

Except in an emergency, it should be a criminal offence for a doctor to prescribe a CD for themselves or a close family member. GPs should notify their PCT that close family members are on their practice list.

Although broadly supporting this recommendation, the Society said guidance was needed on what circumstances constituted 'an emergency'. Schedule 5 CDs should be exempt from this as some are available OTC.

The GMC should publicise that a doctor prescribing CDs to an individual with whom they do not have a professional relationship will be seen as committing professional misconduct. GPs involved in CD offences should immediately inform the GMC, their employer and their PCT. The Government should commission an independent review and audit of whether the GMC and PCTs are using their powers to restrict prescribing rights for GPs involved in CD offences. Details of restrictions surrounding a GP's prescribing rights should be promptly made available, preferably electronically, to those who need to know, especially pharmacists.

The RPSGB supported limitations on prescribing rights for those prescribing CDs. In addition, the NHS IT strategies should support greater access by pharmacists to information about the registration status of those individuals who prescribe CDs.

Welcoming the recommendation that medical practitioners should inform the GMC of any conviction or caution in connection with a CD offence, the RPSGB said it would provide similar guidance for pharmacists and pharmacy technicians in its revised *Codes of Ethics*.

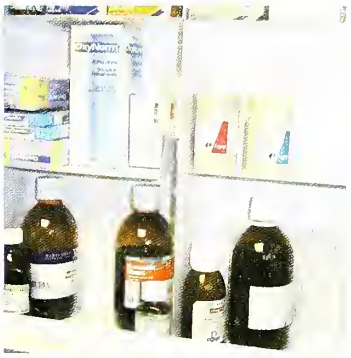
A special form for CD prescriptions in the NHS and private practice should be available to be completed by hand. Prescribers should be encouraged to print it electronically and copy the information by hand. Existing handwriting arrangements should be repealed only when computer generation and/or transmission of CD prescriptions is sufficiently secure. The form should be formatted to allow the PPA to scan prescribing information into a database for analysis.

An alternative solution would be for a standardised private prescription form to be introduced, based on the format of NHS prescriptions but distinct enough to prevent confusion.

For CD prescribing within the NHS, consolidation of the current community NHS prescription forms would enable misuse to be more readily identified.

Only by collectively monitoring private and NHS prescriptions in addition to standardisation of prescription forms will the level of scrutiny and control increase sufficiently.

Computer-generated CD prescriptions should be implemented as soon as possible and electronic transmission of CD prescriptions should be adopted once robust, secure systems are in place. But the handwriting on computer-generated prescriptions proposal was onerous and would not provide significant benefits to patient care, or reduce forgery risks.



The quantity of CD drugs that can be dispensed on a single prescription should be limited to 28 days

Prescribers should use their own pad for CD prescriptions, which shows their GMC number. The prescriber should indicate on the form if it is an NHS or private prescription. Each prescription should have a unique identification number. The form should have space to include the patient's condition until pharmacists have access to patient

Continued on page 36 ▶

Up to half the population will be afflicted with piles, or haemorrhoids to use the more clinical description, at some stage in their lives. While the condition might be the subject of much toilet humour, the reality can be more painful

Haemorrhoids are swollen blood vessels in and around the anal canal. They develop from the normal haemorrhoidal tissues – the vascular anal cushions that form part of the continence mechanism – and are typically caused by straining on defecation.

Haemorrhoids are described as internal or external, these terms relating to their origin rather than whether they are inside or outside the anus. Internal haemorrhoids originate in blood vessels above the dentate line (the anorectal junction) while external haemorrhoids originate below the dentate line at the lower end of the anal canal, just under the skin around the anus.

Internal haemorrhoids can become so swollen that they get displaced and slide down outside the anal sphincter, forming a prolapsed (or protruding) haemorrhoid. This tends to happen during defecation. Prolapsed haemorrhoids will often spontaneously return inside the anal canal, but sometimes they have to be pushed back in. In more severe stages, the haemorrhoid is permanently prolapsed.

Patients can suffer from internal and external haemorrhoids at the same time.

Causes

Haemorrhoids are common in both men and women, with prevalence increasing with age. It is estimated that up to half the population will suffer from haemorrhoids at some point in their life.

Predisposing factors include chronic constipation, prolonged straining, and other conditions that raise intra-abdominal pressure and cause the haemorrhoidal vessels to enlarge, such as obesity and chronic cough. Haemorrhoids are common in pregnancy, and can be aggravated by pushing in labour, but the problem usually resolves soon after the birth.

People whose job involves heavy lifting form another risk group. There is also thought probably to be some genetic predisposition to haemorrhoids.

Certain prescription and over-the-counter drug treatments can cause constipation and should be considered as possible contributing factors. Overuse of stimulant laxatives, which can lead to constipation, might also need to be considered. Chronic diarrhoea can be another risk factor for development of haemorrhoids, because of irritation of the anal canal.

Contrary to schoolboy myths, haemorrhoids are not caused by sitting on hot radiators or cold floors!

Symptoms

Haemorrhoids are often asymptomatic but they can cause itching, bleeding, discomfort, a feeling of incomplete evacuation after a bowel movement, and (less commonly) pain.

The most common symptom of internal haemorrhoids is bleeding, especially after a bowel movement when passage of the stool causes a small blood vessel in the anal cushions to burst. The blood is typically seen as small spots of fresh red blood on the toilet paper. Mucus discharge can occur with prolapsed haemorrhoids and this can cause irritation.

Non-prolapsed internal haemorrhoids are not painful, as the mucosa above the dentate line has no sensory pain fibres. Prolapsed internal haemorrhoids can be painful.

External haemorrhoids can form a swelling or hard lump around the anus. This is a thrombosed haemorrhoid and can be extremely painful.

OTC treatment

Haemorrhoids are not normally serious and most cases will clear up on their own within a couple of weeks. However, sufferers often want prompt symptom relief and there are a variety of over-the-counter products that can help to reduce discomfort.

Common constituents of OTC products for symptomatic management of haemorrhoids are astringents, soothing agents, local anaesthetics and anti-inflammatory agents. They are available in a range of formulations – creams, ointments, suppositories, sprays and gels – most of which contain a combination of constituents. If products are applied internally, it is important that any applicator is used with care to avoid further tissue damage.

Most of the haemorrhoidal treatments are intended for use morning and evening, and after each bowel movement.

Hydrocortisone is present as an anti-inflammatory agent in ointment, spray and suppository haemorrhoidal formulations. These products can be effective in relieving discomfort. The OTC licences restrict use to a maximum of seven days and the products should not be used in pregnancy.

Preparations containing local anaesthetics, such as lidocaine and benzocaine, can help to reduce itching and pain. However, they should not be used for more than a few days because of the risk of sensitisation of the anal skin.

Astringents can help to relieve irritation. Those present in haemorrhoidal products include bismuth compounds, zinc oxide, allantoin, hamamelis and peru balsam. These compounds help to shrink swollen and inflamed skin. Astringents are also said to form a barrier on the surface of damaged skin, which has a protective, soothing effect.

Some of the ingredients also have mild antiseptic properties.

Haemorrhoids: When to refer

- **OTC treatment does not produce symptomatic relief**
- **Rectal bleeding**
- **Additional symptoms, eg abdominal pain, weight loss, recent change in bowel habit**
- **Severe pain – this may indicate an anal fissure or tear**
- **Possibility of drug-induced constipation**
- **Patient is a child – haemorrhoids are rare in children**

When to refer

Although mild haemorrhoidal symptoms can be relieved by self-medication, pharmacists should question patients about their symptom to determine whether medical referra is needed (see left). If self-treatment is chosen, patients should be encourage to seek medical advice if their symptoms do not improve within about seven days.

Rectal bleeding is often due to haemorrhoids, but it can also be a symptom of more serious conditions and, ideally, all patients with rectal bleeding should be referred. Some might instead choose to self-treat, but referral is certainly recommended if t blood is mixed with the stool (as opposed to slight streaking on the surface) or if the blood is dark, as this indicates that it has come from highe up the gastrointestinal tract. Referral

lso needed if there are additional "warning symptoms" such as nausea or abdominal pain, weight loss or recent change in bowel habit. Patients aged over 50 who have rectal bleeding should be referred because of the increased risk of colorectal cancer in this age group.

Advice to customers

ince constipation can both cause and ggravate haemorrhoids, the most mportant factor in helping the ondition to resolve is to avoid onstipation. Eliminating straining will elp to relieve symptoms and help to revent the haemorrhoids from rotruding.

Dietary change is the best approach o constipation. It can be useful to offer atients advice about increasing the ore content of their diet. Lack of high ore foods in the diet and inadequate uid intake means the stools become ard, which increases straining during a owel movement. It is important that creased fibre intake is accompanied v increased fluid intake. The aim is to roduce soft but well formed stools. If ecessary, a bulk-forming laxative might so be recommended.

Warm baths several times a day, in ain water, can help to ease mptoms. For very painful protruding es, applying an ice pack to the area voiding direct contact of ice with the in) for a short time can reduce elling.

Perianal hygiene is important to event further irritation by faecal atter. It is helpful to clean the area th warm water after each bowel ovement – medicated toilet tissues n be useful for situations when ashing is not practicable.

medication records. Each patient should have a unique identification number that is entered on every prescription.

It supported the suggestion that prescribers should use their own pad for all POMs as a matter of good practice. A prescriber should be required to record their name and professional registration number (or similar unique identifier) on each prescription they issue. However, a prescription without this should not be deemed invalid so long as the pharmacist judges it to be a purely technical breach.

The pharmacist would need to confirm the prescriber's number retrospectively to comply with subsequent recommendations for CD Register (CDR) records. The Society suggested it should be treated like any other technical defect, with the pharmacist able to amend and dispense the prescription without returning it to the prescriber.

The Society expressed concern for confidentiality if the patient's condition was included on prescription forms, but supported the recommendation to give pharmacists access to PMRs.

A prescriber's failure to add a unique patient identifier number to a prescription should not invalidate it if the pharmacist judges it to be a purely technical breach.

The quantity of CD drugs that can be dispensed on a single prescription should be limited to 28 days. The prescription's validity should be restricted to 28 days. Schedule 5 drugs would be exempt. Times should be recorded when an electronic CD prescription is created and dispensed.

The Society broadly supported restrictions on prescription validity and quantity to be dispensed for CDs, providing patient care was not compromised and patients were aware of expiry dates.

Pharmacists should have discretion to dispense 28 days' supply if a prescriber inadvertently prescribes more than 28 days' supply, provided the pharmacist judges this to be a technical defect. The introduction of this restriction will require prescription directions such as 'one as directed' to be deemed insufficient for the purposes of prescribing Controlled Drugs.

Additional prescribing guidance may be required and the *British National Formulary* should be amended accordingly.

For patients in chronic pain, the Society recommended prescriptions with a start and an expiry date to ensure continuity of care.

Although the Society supported the noting of prescribing and dispensing times for CD prescriptions, it warned that the time of assembly will differ from the time the patient receives the medication.

Pharmacists should be able to dispense CD prescriptions with purely technical defects and when they are confident of the prescriber's intentions.

Giving pharmacists the discretion to amend CD prescriptions with technical defects without returning the prescription to the prescriber was welcomed and the Society said it will produce practice guidance on this. Consideration will need to be given to whether the implementation of this recommendation will require amendment to legislation.

Pharmacists should record the name and address of the person collecting a CD prescription and ask to see ID of a person unknown to them. This information should be recorded in the CDR. The pharmacist has discretion to supply in cases when no ID is supplied and record this in the CDR.

Healthcare professionals acting in their professional capacity should provide ID when presenting a prescription or requisition for CDs. This supply and relevant information should be recorded in the CDR. Persons collecting Schedule 3 and 4 CDs should be required to write and sign their name on the reverse of the prescription form. Pharmacies should be permitted to keep electronic CDRs.

The Society supported the recommendations for health professionals requiring ID when collecting CDs and for individuals signing the back of prescriptions for Schedule 3 and 4 drugs. It expressed concern over patient confidentiality if ID was required for dispensing CDs. In addition, the possibility of violence against a pharmacist who refused to supply CDs to someone without ID was highlighted.

The Society expressed concer over whether a pharmacist, actin in good faith and in the patient's best interests, could be deemed t have committed a criminal offen by supplying a CD to a person without ID.

Electronic CDRs were welcomed by the Society with th proviso that the system has a regular back-up facility and adequate security.

Keeping running balances in pharmacy CDRs should be regarded as good practice. When electronic CDRs are in general use, running balance should be obligatory.

Although the Society supporte the recommendation, it suggeste that, when running balances become a legal requirement, ther should not be a strict liability offence if there is a reconciliation problem with a justifiable reason Specific requirements on reconciliation should be devised for liquid preparations of CDs used in treating drug misuse. It suggested guidance on liquid preparations, reconciliation frequency and action to be taker when discrepancies occur.

The prescriber's name and professional registration number should be entered in the CDR along with the pharmacist responsible for supplying CDs to the patient their representative.

The Society supported this recommendation and added the name and registration number the pharmacist who supplied th CD should be legibly recorded t create an audit trail. A record of details covering the pharmacist who supervises assembly and th pharmacist who supervises supp should be in place, it added.

The RPSGB should offer guidance to pharmacists abo imparting information about CDs to patients and their representatives. It should include information on the

drug, keeping it safe because of the risk of diversion. Patients should return unused drugs to the pharmacy. Information should be given in written and oral forms.

The Society broadly supported the recommendation, but added that all POMs should be covered by these guidelines as they were also potent and capable of abuse. However, it warned that informing patients' representatives about the nature of CDs could impact on pharmacists and their role in patient confidentiality and increase the risk of diversion of the drugs.

Pharmacists should be required to prepare a statutory patient drug record card (PDRC) to accompany every supply of injectable Schedule 2 drugs leaving the pharmacy. This should record the form and amount of drug prescribed, the form and amount of drug dispensed and the dosage instructions as they appear on the prescription.

A master PDRC should be used to record administration, supply and a running balance of Schedule 2 injectable drugs by healthcare professionals. After a patient's death, the PDRC should be sent to the PCT, examined for anomalies and married up with the GP's records. The proposed CD inspectorate could carry out occasional PDRC audits.

The RPSGB supports the introduction of a Patient Drug Record Card but would wish to be consulted on proposals about any new system to ensure efficiency.

Consideration should be given to changing the law so that all CDs would become the property of the Crown on the death of the patient for whom they were prescribed.

There should be increased formality attached to the destruction of injectable Schedule 2 CDs dispensed for administration in the community. Their destruction and their removal from the home of the patient should be properly recorded and witnessed. The classes of person lawfully entitled to undertake or witness destruction should include doctors, pharmacists, nurses, suitably trained law enforcement officers or PCT officers, and inspectors of any new Controlled Drugs inspectorate.

The Society recommended all POMs become Crown property upon a patient's death and the change be supported by a public awareness campaign.

It welcomed the recommendation for tighter controls on the destruction of CDs but would want its inspectors and other authorised pharmacists to retain authority for witnessing CDs' destruction.

It expressed concern that patients and the public may not know the distinction between different drugs and could be deterred from returning any unused medicines to the pharmacy.

It recommended further consideration and suggested a public awareness campaign to encourage people to return all unused drugs to pharmacists.

For more information:

www.the-shipman-inquiry.org.uk

www.rpsgb.org.uk

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REF NO: 49714006

For the above 2 posts, a full current driving licence and access to a car is essential. Consideration will be given to alternative travelling proposals in respect of applicants with a disability who cannot hold a licence.
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Jyoti Patel

Charles Maxwell

Jyoti Patel has joined AAH as marketing manager for its hospital service division. Prior to this, Ms Patel was product strategy manager at utility company Npower. In her new role, she will be focusing on developing stakeholder relationships and communication strategy.

UniChem has announced the appointment of **Charles Maxwell** as general manger for the Exeter distribution centre. Mr Maxwell has been with the company since 1999 when he joined as operations manager.

All hail MacDuff, 2004 winners

This year's Lloydspharmacy of the Year title has been won by the MacDuff, Aberdeenshire branch.

The store's staff received their trophy and £2,000 prize money at an awards ceremony held at Coventry's Royal Couth Hotel earlier this month. Pharmacy manager Pamela Wilson said: "We're extremely proud and excited that we won. This is a small fishing town where we have a strong sense of community – it means so much to be recognised for our efforts in providing the very best healthcare advice."

Lloydspharmacy managing director Justin Ash said choosing an overall winner had been difficult because of the high standard of entrants, but added: "MacDuff won through their outstanding commitment to their customers and growing services."

Other finalists who attended the GlaxoSmithKline-supported event included staff from branches in Hull, Birmingham and Jersey. The pharmacies were judged on customer standards, profitability, OTC performance and meeting targets.

Pictured from the left are: healthcare assistant June Gedded, area manager Liz Scott, pharmacy manager Pamela Wilson, healthcare assistant Amanada Gill and trainee healthcare assistant Colleen Ewen

A choc-tastic celebration marked the launch of IVAX's new asthma inhaler Qvar Easi-Breathe. Pictured from the left are: Jonathan Westlake, commercial generics product manager; Frank Condella, European region president; Guy Clark, new business development director; and Alexandra Thrower, European region senior legal counsel

Cannabis? One is highly amused

The Home Office has approved a licence to grow cannabis, magic mushrooms and opium poppies for an unexpected person – and royalty at that.

But home secretary David Blunkett is unlikely to be worried about adverse publicity in the tabloids. The permission has been granted to the Duchess of Northumberland who will be growing the drugs in her garden at Alnwick Castle.

The plants will form part of the Poison Garden, an educational development in the castle grounds. Also featured will be tobacco, foxglove and wild lettuce, and castor oil plants which are used to produce the nerve agent ricin.

The display is likely to prove popular with schoolchildren, but they won't be able to make off with any 'samples'. Access to the walled garden will be controlled and visitors will be escorted to ensure they do not touch any plants.

Wendy Price of Sainsbury's Pharmacy in Burnley, Lancashire was the lucky winner of the Pharmacy Travel competition run in the September issue of *C&D*'s sister publication, *Community Pharmacy*. Ms Price is now happily planning her break in London, and said: "I have never won anything before and wouldn't believe it until I received something in writing. Thank you ever so much"

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